(10)

No. 97-689-CFX Title: Bonnie L. Geissal, Beneficiary and Representative of the Estate of James W. Geissal, Deceased, Petitioner
v.
Moore Medical Corporation, et al.

Docketed:
October 21, 1997 Court: United States Court of Appeals for the Eighth Circuit

Entry	Date	Proceedings and Orders
	Oct 20 1997	Petition for writ of certiorari filed. (Response due December 22, 1997)
	Nov 19 1997	Order extending time to file response to petition until December 22, 1997.
	Dec 22 1997	Brief of respondents Moore Medical Corp., et al. in opposition filed.
	Jan 7 1998	DISTRIBUTED. January 23, 1998
	Jan 23 1998	Petition GRANTED. The brief of petitioner is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Wednesday, March 4, 1998. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Monday, March 30, 1998. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, April 14, 1998. Rule 29.2 does not apply. SET FOR ARGUMENT April 29, 1998. **********
	Mar 4 1998	Joint appendix filed.
	Mar 4 1998	Brief of petitioner Bonnie Geissal filed.
	Mar 4 1998	Brief amicus curiae of United States filed.
	Mar 4 1998	Motion of American Association of Retired Persons for leave to file a brief as amicus curiae filed.
	Mar 4 1998	LODGING consisting of ten copies of Internal Revenue Service Announcement 98-22, submitted by the Solicitor General
	Mar 13 1998	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Mar 23 1998	Motion of American Association of Retired Persons for leave to file a brief as amicus curiae GRANTED.
	Mar 23 1998	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Mar 30 1998	Brief amicus curiae of Health Insurance Association of America filed.
	Mar 30 1998	Brief of respondents Moore Medical Corp., et al. filed.
	Apr 1 1998	CIRCULATED.
	Apr 6 1998	Record filed.
	Apr 6 1998	Record filed.
	Apr 13 1998	Reply brief of petitioner Bonnie Geissal filed.
	Apr 29 1998	ARGUED.

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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL
as representative of the
Estate of JAMES W. GEISSAL, deceased,
Petitioner,

v.

MOORE MEDICAL CORP.,
GROUP BENEFIT PLAN OF MOORE MEDICAL CORP.,
and HERBERT WALKER,
Respondents.

Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

I. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which provides that health insurance coverage may not be suspended until the worker ("qualified beneficiary") first becomes, after the date of the election, covered under any other group health plan, 29 U.S.C. §1162(2)(D)(i), does preexisting spousal/domestic partner health insurance coverage disqualify the beneficiary from his own right to COBRA continuation coverage?

II. If preexisting spousal/domestic partner health insurance coverage does disqualify a worker from his own right to continue at his expense health insurance coverage under COBRA except when the preexisting coverage is somehow insufficient ("gap"), what is the nature of such "gap," how should such "gap" be measured, and who bears the burden of going forward and proof on such "gap" issue, the worker, the employer, the benefit plan or the health insurer?

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PETITION FOR WRIT OF CERTIORARI

Plaintiff respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, which affirmed the decision of the district court, on June 10, 1997, so that this Court might resolve an irreconcilable split between the Seventh and Tenth Circuits on one hand, and the Eighth, Eleventh and Fifth Circuits on the other, with respect to the employer obligation to continue to offer health insurance under COBRA when there is preexisting spousal/domestic partner coverage. There are two compelling reasons for review: first, the strong Congressional desire for national uniformity in enacting the Employee Retirement Income Security Act (ERISA), a goal often expressed by this Court in ERISA decisions, and second, importance of health insurance coverage concerns and the serious effect that loss of health insurance coverage may have on a large segment of the population.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, rendered June 10, 1997, is reported at 114 F.3d 1458, and is reprinted in the appendix hereto as A-1 to A-18. A petition for rehearing or rehearing en banc was denied July 30, 1997, and appears in the Appendix as A-19. The opinion of the United States District Court for the Eastern District of Missouri is published at 927 F.Supp. 352 and is reprinted in the Appendix at A-20 to A-36.

JURISDICTIONAL STATEMENT

The district court had jurisdiction of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §§1132(a) and 1161. During the course of the proceedings in the district court, the original plaintiff died and the personal representative of his estate was substituted as party plaintiff. She is the petitioner herein. The

magistrate judge acting under consent given pursuant to 28 U.S.C. §636(c)(1) denied summary judgment to petitioner and on its own motion granted summary judgment in favor of defendants/respondents on Counts I and II. Final judgments were entered on those counts under Fed. R. Civ. P. 54(b).

An appeal was taken to the Eighth Circuit Court of Appeals pursuant to 28 U.S.C. §1291. The judgment of the Court of Appeals was entered June 10, 1997. Petitioner filed a petition for rehearing by the panel or, alternatively, for rehearing en banc. The Court of Appeals denied the petition July 30, 1997.

Pursuant to Supreme Court Rule 13.1, this petition has been filed within 90 days of the denial of rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254(1).

STATUTE INVOLVED

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") 29 U.S.C. §§1161(a) and 1162(2)(D)(i), provides:

§1161 Plans must provide continuation coverage to certain individuals

(a) In general

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

§1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(D) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) "which does not contain any exclusion or limitation with regard to any pre-existing condition of such beneficiary", . . .

STATEMENT OF THE CASE

The petitioner's decedent, James Geissal, referred to as "James" in the Eighth Circuit's opinion, worked for respondent Moore Medical Corporation (Moore), and while so employed was entitled to health care benefits from a group plan established by Mr. Geissal's employer. Mr. Geissal's wife, the petitioner in this petition in her capacity as personal representative of his estate, worked for Trans World Airlines (TWA), which provided for its employees and their spouses health care benefits through its group health plan. The TWA plan was administered by Aetna Insurance Company. The Moore plan had no coordination-of-benefits provision, and a lifetime maximum for payments it would make. The plan sponsored by TWA made it secondary to payments by the Moore plan, and it too had a lifetime maximum limited to payments it alone would make. Had Mr. Geissal exceeded the maximum lifetime of the Moore plan, he would have immediately started receiving benefits from the TWA plan; he would not have to wait until his employment was terminated. He did not in fact exceed the maximum.

James Geissal suffered from cancer, and his employment was terminated by Moore. He had not exceeded his lifetime cap

imposed by the Moore plan at the time of his termination. That termination was a COBRA-qualifying event. At the time of termination, Moore and its plan administrator both assured Mr. Geissal of eligibility for COBRA continuation and encouraged him to so elect to continue his coverage and pay premiums. James Geissal exercised the right of election Moore offered and paid premiums to respondents under COBRA. He wanted to protect himself and his estate from the high cost of cutting-edge medical treatments to treat the cancer, and he was concerned that the maximum of lifetime benefits in only one plan may not be sufficient for the aggressive care he intended to fight his cancer. He also had in mind the fact that the deductibles under the TWA plan were greater. After accepting some six months of COBRA premiums, and as medical expenses for his cancer treatments were rising, respondents suddenly advised Mr. Geissal that he was not entitled to and ineligible for COBRA coverage; no bills for medical coverage were paid by the Moore plan. They proposed to pay back his premiums. Mr. Geissal instituted this action to secure his COBRA rights, in the district court pursuant to 28 U.S.C. §1331 and 29 U.S.C. §§1132(a) and 1161.

After filing his motion for summary judgment in the district court, Mr. Geissal succumbed to the cancer. His widow, petitioner herein, was appointed personal representative of his estate by the Circuit Court of St. Louis County (Probate Division), Missouri, and was allowed to be substituted in his place by order of the magistrate judge.

REASONS FOR GRANTING THE WRIT

I. There is an irreconcilable split in the circuits and a threat to both geographical uniformity of employer obligations under benefits law and to health of the persons adversely affected by the decisions of three circuits which do not permit COBRA continuation in the event of preexisting health benefits/insurance coverage provided by a collateral source, such as the spouse's employer

This case is compelling for review and resolution by this Court. The five circuits which have addressed the issue are irreconcilably split, as the Eighth Circuit in the instant case notes. *Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1465-66 (8th Cir. 1997). The Seventh and Tenth Circuits hold that preexisting spousal/domestic partner coverage does not fit the statutory definition unless one disregards the words "first" and "after" in 29 U.S.C. §1162(2)(D)(i), compelling COBRA continuation. *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989). See also *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W.2d 619 (S.D. 1993). In addition to the Eighth Circuit in the instant case, the Fifth and Eleventh Circuits attempt to read in some hidden Congressional meaning to sparse, hardly existent legislative history,[1] to disre-

[1] See T. H. Somers, "COBRA: An Incremental Approach to National Health Insurance," 5 J.Contemp. Health L. & Pol'y 141 (April, 1989). Under a heading entitled "COBRA: A 'Middle of the Night" Enactment?", he noted that Congress enacted COBRA "without deliberation and in the process of amending three distinct statutes," causing:

> a fair amount of regulatory confusion and bureaucratic tension. . . . Absent solid statutory or regulatory guidance for a legislative history that unravels COBRA's complexity, one commentator has asked whether COBRA was rationally considered, a 'middle of the night'

(Footnote 1 continued on next page)

gard the words written, holding COBRA does not compel continuation if there is preexisting coverage. *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991).

Any national employer who offers a health benefits package to its workers is compelled by decisions of the Seventh and Tenth Circuits to offer COBRA continuation to its employees in the states covered by those circuits, while for those employees sandwiched in between, the states within the Eighth Circuit, and to its Southern workers in states within the Fifth and Eleventh Circuits, that same employer does not have to offer the same continuation coverage or may withdraw it ab initio once it determines there was preexisting spousal/domestic partner coverage.

Several circuits have not yet addressed the issue, which puts not only beneficiaries in threat of having insufficient health care coverage, as the Fifth Circuit makes evident, *Brock v. Primedica, Inc.*, *supra*, but employers operating in those areas are in a quandary, especially when, if they elect to follow the views of the Eighth, Fifth and Eleventh Circuits, and it later turns out the particular circuit follows the Seventh and Tenth Circuits, they face not only restoration of benefits, but substantial daily penalties provided under 29 U.S.C. §1132(c)(1).

(Footnote 1 continued)

> addition to the Budget Reconciliation Act. [Footnote omitted] Indeed some might argue that COBRA is symptomatic of Congress' growing inclination to delegate unlimited legislative authority to the other branches of government. The absence of legislative direction, of course, is where federal agencies and, inevitably, the courts are often called upon to divine legislative will.

The author then intones, presciently, "we should expect much of the same in COBRA's future."

It was this compelling concern for national uniformity of results that led this Court to accept review in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). See also *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) (Congressional desire to avoid "patchwork scheme of regulation"). The fact that in *Firestone* it was the employer appealing for need for national uniformity in all its plants in various parts of the country, suffering different results depending upon the particular circuit, while here it is a single worker raising the same concerns for uniformity, should not skewer the need for this major issue to be resolved now. How health care is to be made available is far more a pressing issue nationally than severance pay. The Eighth Circuit below noted in the instant case,

> ...the federal courts have experienced significant difficulty in attempting to grasp the true meaning of 29 U.S.C. § 1162(2)(D)(i). Our efforts, though unquestionably well intentioned, have inevitably led to at least two separate and irreconcilable interpretations of the law. This deepening rift is extremely troublesome to us, especially given the proliferation of group health plans and the importance of guaranteeing equivalent protection to all ERISA beneficiaries throughout this nation. Accordingly, we suggest that some definitive action, originating either from Congress or the Supreme Court, might be appropriate.

The issue cries out for resolution now, as the Department of Labor considers issuing new guidelines on COBRA. See "Labor Department Considers Need for Guidance on COBRA Provisions," 66 U.S. Law Week 2185. Congress did not choose to clarify the statutory provision or did not see any need to clarify, when well after the decision of the Seventh Circuit in *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, *supra*, and before the decision of the Eighth Circuit for which review is now sought, it enacted other changes to COBRA in Section 421

of the Health Insurance Portability and Accountability Act, Pub. L. 104-191, but made no change to §1162(2)(D)(i).

Resolution is also needed, for the creation of the legal fiction that the preexisting spousal/domestic partner policy comes into effect only "after" employment has been terminated, could threaten the worker's right as beneficiary of the spousal/dependent coverage to bring any action prior to the COBRA-qualifying event to challenge COB determinations or to determine his/her rights to future benefits in the plan of the spouse/domestic partner, expressly allowed to beneficiaries by 29 U.S.C. §1132(a)(1)(B). Such likely disenfranchisement based on a later fictional effective date merits examination by this Court in considering the split.

II. If there is to be an exception to a determination that §1162(2)(D)(i) provides that preexisting spousal coverage eliminates any COBRA obligation of the employer, there is similar compelling need for uniformity with respect to the nature of such exception, and who bears the burden of going forward and proof on such exception issue

The Fifth, Eighth and Eleventh Circuits all propose to allow exceptions, based on their views as to whether there is a "significant gap" between what benefits the employer provides and what is the coverage provided in the preexisting spousal/domestic partner policy. There is no legislative guidance (or warrant) whatsoever to establish what is a "significant gap," and there is no uniform judicial approach.

In the Eighth Circuit it used to be just how much was involved after the bills were incurred, as in *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994) (*dicta*, $7,500 is a significant gap), but the instant decision for which review is sought now insists on a foresight test that district courts seem now to favor. See, *e.g.*, *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 845 F.Supp. 1275 (N.D. Ind. 1994), reversed, 51 F.3d 1308 (7th Cir. 1995); *Schlett v. Avco Financial Services, Inc.*, 20 EBC 2077, 2085-86 (N.D. Oh. 1996) ($7,000 actual gap irrelevant, review of cases).

Under *Brock v. Primedica, Inc.*, *supra*, one does not consider what the amount of the foreseeable expense might be and the adequacy of coverage, but solely to see if the condition was covered in both policies. That is also the view of the Eleventh Circuit. *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, *supra*, 929 F.2d at 1569, 1571 (fact that lack of dual coverage leaves a gap of over $7,000 because preexisting policy did not pay all expenses, is irrelevant).

In contrast to the Eleventh Circuit, the Eighth Circuit talks not in terms of any particular condition, but in terms of "comparable group health programs," 114 F.3d at 1465, and calls for examination of overall plan terms, to see if the preexisting plan "offered appreciably fewer benefits . . . or limited coverage for treatment likely necessary for a cancer patient in James' condition." *Geissal v. Moore Medical Corp.*, *supra*, 114 F.3d at 1465. Citing with approval the dissent in *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, *supra*, 51 F.3d at 1318, the Eighth Circuit talks approvingly of "potential of substantial liability" under the preexisting plan (called "new plan") "that does not exist under the old." 114 F.3d at 1465.

Hence, even amongst the "gap" courts there is no agreement as to just what or how to measure, putting employers in a quandary. And workers are now subject to a "quantum of proof necessary to demonstrate a significant gap in coverage," *ibid.*, a burden that Congress did not indicate should be borne by those it intended to protect.

For the same reasons expressed for review of the irreconcilable split in the circuits, that is, need for national uniformity, the effect of approach on health issues and the DOL guidelines, this

second question deserves addressing even if this Court accepts the fiction of the Eighth Circuit that the preexisting coverage did not come into being until after the occurrence of the COBRA qualifying event.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 96-2285

Bonnie L. Geissal, as beneficiary and representative of the Estate of James W. Geissal, deceased, individually and in a representative capacity on behalf of the Group Benefit Program of Moore Medical Corp.,

Plaintiff - Appellant,

v.

Moore Medical Corporation;
Group Benefit Plan of Moore Medical Corp.;
Herbert Walker,

Defendants - Appellees.

Appeal from the United States District Court
for the Eastern District of Missouri.

Submitted: December 11, 1996
Filed: June 10, 1997

Before FAGG, FLOYD R. GIBSON, and LOKEN, Circuit Judges.

FLOYD R. GIBSON, Circuit Judge.

James Geissal filed this suit against his former employer, its group health plan, and the plan administrator (collectively the "Plan"), claiming primarily that the Plan violated certain portions of the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA"), as amended, *see* 29 U.S.C. §§ 1161-1169 (1994), when it rejected his efforts to obtain continuation insurance benefits following the termination of his employment. On

motion for partial summary judgment, the district court[1] determined that Geissal, who at the time of his discharge was also insured under a group health plan sponsored by his wife's employer, was not entitled to take advantage of the continuation coverage mandated by COBRA. The district court also concluded the record does not support Geissal's assertion that the Plan should be equitably estopped from denying him COBRA benefits. Bonnie Geissal, who was substituted as plaintiff upon James Geissal's death, appeals the district court's decision, and we affirm.

I. BACKGROUND

When Moore Medical Corporation ("Moore") fired James Geissal[2] on July 16, 1993, he had been employed by the company for a little over seven years. During his tenure with Moore, James, who suffered from cancer, participated in the group health plan the corporation offered to its employees. *See* 29 U.S.C. § 1167(1) (1994) (defining "group health plan" for purposes of COBRA's continuation requirements). At the same time, James was a beneficiary under a plan provided by his wife's employer, Trans World Airlines ("TWA"), through Aetna Life Insurance Company ("Aetna"). Put simply, then, James enjoyed "dual coverage" before he lost his job.

In an affidavit submitted to the district court, James stated that he was unhappy about the circumstances surrounding his termination and even requested, pursuant to Missouri law, a "service letter" from Moore detailing the grounds for his discharge.[3]

[1] The HONORABLE DAVID D. NOCE, United States Magistrate Judge for the Eastern District of Missouri, who presided over the case with the consent of the parties in accordance with 28 U.S.C. § 636(c) (1994).

[2] For ease of discussion, throughout the remainder of this opinion we often identify James Geissal by his given name, "James." We use the surname "Geissal" to refer to the appellant, Bonnie Geissal.

[3] The Missouri legislature requires certain corporate employers, upon request and under statutorily prescribed circumstances, to furnish disassociated employees a signed writing "truly stating for what cause, if any, such employee was discharged." Mo. Ann. Stat. § 290.140 (West 1993).

According to the affidavit, though, James ultimately declined to "consult with an attorney to investigate and to determine what rights and claims [he] might have [had] against Moore," Geissal's App. at 23, because Moore promised to afford him an opportunity under COBRA to maintain his health insurance. James further claimed that, based on these assurances, he failed to locate an alternative policy to supplement the insurance he received from his wife's employer.

After receiving an "election form" outlining his COBRA rights, James chose to receive continued coverage under Moore's group health plan. As such, James made premium payments, which Moore accepted, for approximately six months after his last day of work. Nonetheless, by letter dated January 27, 1994, the plan administrator informed James that he was ineligible for COBRA benefits because he was already covered under TWA's group policy. As a result, the insurer declared its intention to reimburse James for the premiums he had tendered, and it also returned billings that had been submitted by the cancer patient's medical care providers.

James subsequently initiated this suit, principally asserting that the Plan violated COBRA when it canceled his insurance coverage. Following limited discovery, James moved for summary judgment against the Plan on counts one and two of his four count Complaint. The district court denied James's motion and instead entered summary judgment in the Plan's favor on the two causes of action. *See Geissal v. Moore Med. Corp.*, 927 F. Supp. 352, 361 (E.D. Mo. 1996) (citing *Madewell v. Downs*, 68 F.3d 1030, 1048-50 (8th Cir. 1995) (recognizing a district court's prerogative to grant summary judgment *sua sponte* where the party against whom judgment will be entered has received adequate notice and an opportunity to respond)). In particular, the court decided that COBRA does not, in most cases, compel an employer to furnish continuation benefits to a discharged employee when the individual is also insured under another

group plan. *See id.* at 358-60. The court additionally determined that James had not proffered facts sufficient to substantiate his claim for equitable estoppel. *See id.* at 360-61. Consequently, the court dismissed counts one and two, but ordered additional proceedings relating to the remaining grounds for relief. Bonnie Geissal, who by this time had replaced her husband as plaintiff, petitioned the court to make appropriate findings under Rule 54(b) of the Federal Rules of Civil Procedure, thus permitting an immediate appeal from the partial grant of summary judgment. The Plan did not challenge the motion, and the court granted Geissal's request by entering final judgment on counts one and two and staying further action pending our resolution of this interlocutory appeal.[4]

II. DISCUSSION

A. COBRA

The "staggering budget deficits now facing the United States" prompted Congress to pass COBRA in 1986. S. Rep. No. 99-146, at 3 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 43. Ever resourceful, Congress also used this massive piece of legislation as a vehicle to assuage its concern with "the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R. Rep. No. 99-241, pt. 1, at 44 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 622. Namely, Congress included within COBRA amendments to the Employee Retirement Income Security Act of 1974 ("ERISA"), *see*

[4] Dubious of our jurisdiction, we instructed the parties to approach oral argument prepared to discuss the possible prematurity of this appeal. Though we regard this as an *extremely* close case, we are satisfied that the district court acted within its discretion when it authorized Rule 54(b) certification as to counts one and two of Geissal's four count Complaint. *See Hardie v. Cotter & Co.*, 819 F.2d 181, 182 (8th Cir. 1987)(reciting the standards applicable to entries of judgment under Rule 54(b)).

29 U.S.C. §§ 1001-1461 (1994), which require sponsors of group health plans to extend temporary continuation insurance benefits to individuals who lose coverage due to certain qualifying events, *see* 29 U.S.C. § 1161(a).

Normally, "qualified beneficiar[ies]," including employees and their spouses and dependents, *id.* § 1167(3)(A), are entitled to receive continuation coverage for eighteen or thirty-six months, depending upon the nature of the qualifying event, *see id.* § 1162(2)(A). Aware that this lingering obligation could prove burdensome to group health plans, however, Congress enacted exceptions that permit earlier termination of benefits if certain conditions are met. *See id.* § 1162(2)(B)-(E). Of present concern is the provision allowing cancellation of COBRA insurance on

> [t]he date on which the qualified beneficiary first becomes, after the date of the election [to obtain continuation benefits]—
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary . . . .

Id. § 1162(2)(D).[5]

The Plan banks on this language to support its decision to terminate James Geissal's coverage. Because James was a beneficiary under his wife's group health program with TWA, the Plan claims this statutory exception rendered it perfectly permissible to declare him ineligible for continuation benefits. Though Geissal does not deny that the TWA plan, administered through Aetna, constituted group health insurance which did not

[5] In the course of this opinion, we cite to the version of the statute applicable to the facts of this case. *Cf.* 29 U.S.C.A. §§ 1162(2)(D)(i), 1181-1191c (Supp. 1997) (containing recent amendments).

"contain any exclusion or limitation with respect to any preexisting condition," *id.* § 1162(2)(D)(i), she insists that the Plan violated COBRA when it canceled James's insurance. Purportedly seizing upon the "plain language" of the Act, Geissal contends that a person is disqualified from receiving continuation benefits only if he procures other coverage *after* he has chosen to secure COBRA insurance; otherwise, the individual does not *first* become covered "under any other group health plan" *after* the date of election. Under this reading of the exception, James retained his eligibility for continuation coverage because his status as a beneficiary under the TWA plan predated his discharge from Moore.

Geissal's interpretation of COBRA is not without supportive authority. The United States Court of Appeals for the Tenth Circuit, the first federal appellate tribunal to consider this question, has held that the exception allows termination of continuation benefits only if the beneficiary obtains other insurance after the date of election. *See Oakley v. City of Longmont*, 890 F.2d 1128, 1133 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).[6] Scrutinizing the disputed language "in light of the entire legislative scheme" enacted by Congress, *id.* at 1132-33, the Tenth Circuit concluded that the statute "contemplates continuation coverage to remain available to the covered employee despite a spouse's preexisting insurance policy," *id.* at 1133. The court explained:

> When we read the [exception's] introductory language in conjunction with "covered under any other group health plan (as an employee or otherwise)," we believe the plain meaning of this subsection cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage. Indeed, [the appellant] did not "first become" covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employee's termination to become a condition triggering "other" coverage under a spouse's preexisting group plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent.

[6] A public employee was the plaintiff in *Oakley*, and the case thus arose under the Public Health Service Act rather than ERISA. The pertinent continuation coverage provisions in the two Acts are, for practical purposes, indistinguishable. *Compare* 42 U.S.C. §§ 300bb-1 to -8 (1994) *with* 29 U.S.C. §§ 1161-1169.

Id. at 1132 (quoting 42 U.S.C. § 300bb-2(2)(D)(i)).

More recently, a panel of the Seventh Circuit, with one judge dissenting, reached the same result, but for slightly different reasons. *See Lutheran Hosp., Inc. v. Business Men's Assurance Co. of Am.*, 51 F.3d 1308, 1312-13 (7th Cir. 1995). That court focused upon what it perceived to be Congressional intent to grant a displaced employee the opportunity to maintain his insurance "status quo." *See id.* The court in large part divined this motivation from the requirement that continuation coverage be "identical to the coverage provide[d] under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." *Id.* at 1313 (quoting 29 U.S.C. § 1162(1))(alteration added). Where an individual is fortunate enough to possess dual coverage before the occurrence of a qualifying event, he will receive "identical" benefits after the event, and thereby preserve his health care status quo, only if given an opportunity to invoke COBRA continuation rights. *See id.* at 1312-13. Elaborating upon this theme, and accentuating its conception of the statute's "plain language," the court observed:

> The statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other

group health plan. The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan. . . . Therefore, an employee loses the right to continuation coverage only if he or she chooses after the election date to accept coverage under another group health plan.

* * *

The plain language of the statute dictates that an individual only loses COBRA eligibility if he or she chooses to accept alternative group health insurance after the qualifying event. By the terms of the statute, the individual has the choice whether to preserve the status quo and continue the prior level of coverage under COBRA or accept alternative coverage and discontinue COBRA. In either case, for the [mandatory] statutory period . . ., the individual is never forced to accept a lower level of health care coverage than he or she received as an employee before the qualifying event.

Id. at 1312; *see also King v. John Hancock Mut. Life Ins. Co.*, 500 N.W.2d 619, 621-23 (S.D. 1993) (adopting parallel interpretation of comparable COBRA exception).

The opinions of two other courts of appeals stand in direct contradiction to *Lutheran Hosp.* and *Oakley*. *See National Cos. Health Benefit Plan v. St. Joseph's Hosp., Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990). These tribunals have emphasized that Congress designed COBRA to provide security for those persons who, as a result of some disruption in their employment, are left without *any* health insurance. *See National Cos.*, 929 F.2d at 1569-70; *Brock*, 904 F.2d at 296. The continuation coverage compelled by COBRA offers limited relief to these individuals by granting them a reasonable amount of time to procure alternative insurance. *See National Cos.*, 929 F.2d at 1570. Once a person does, indeed,

become a beneficiary under another group health plan, the result desired by Congress is achieved, and continuation coverage becomes unnecessary and superfluous. *See id.* In recognition of this fact, the exception at issue allows an employer to cancel continuation coverage whenever an employee receiving those benefits obtains replacement insurance. *See id.* As viewed by the Eleventh Circuit, the provision "clearly includes employees covered under their spouses' preexisting group health plans. In such a setting, the concerns that motivated Congress' enactment of COBRA generally are not present; the employee has group health coverage." *Id.*

The Eleventh Circuit also rejected the notion that the statute's "plain language" commands a different result. Chief Judge Tjoflat, writing for the court, reasoned:

> Congress was concerned with the lack of group health coverage after an employee left his job; therefore, the relevant time period is that following his continuation-coverage election. In applying the termination provision at issue, then, it is clearly irrelevant whether an employee had other group health coverage prior to this election date — an employer cannot refuse to offer continuation coverage to a former employee simply because that ex-employee had other group health coverage during his employment. Instead, Congress allowed ERISA-plan sponsors to terminate continuation coverage only on the first date after the election date that the employee became covered under another group health plan. Thus, it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment

after the election date. In effect, such an employee is ineligible for continuation coverage.

Id. Based on this analysis, the Eleventh Circuit held that an employee who is insured under another group health plan may opt for continuation benefits only if "there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan." *Id.* at 1571. The existence of a significant gap in coverage gives rise to continuation rights because in that situation "the employee is not truly 'covered' by the preexisting group health plan." *Id.*

In dicta, we have previously described as "attractive" the position announced by the Eleventh Circuit on this issue. *see McGee v. Funderburg*, 17 F.3d 1122, 1124 (8th Cir. 1994), but in *McGee* we gave "greater significance [to] the definition of 'cover[age] under any other group health plan,'" *id.* We do, however, take this occasion to explicitly follow the approach adopted by the Eleventh Circuit.[7] Having comprehensively reviewed both the language of the relevant exception and its function within the larger framework of COBRA, along with what little legislative history is available to shed light on the subject, we find ourselves in disagreement with the Seventh Circuit's decision that continuation benefits were crafted to allow an individual to maintain his insurance "status quo." *See Lutheran Hosp.*, 51 F.3d at 1312-13. Rather, we are convinced that Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves "without any health insurance cover-

[7] Though the effective statutory language in *National Cos.* predated the 1989 amendments to COBRA, which are operative in the present appeal, this circumstance does not make the Eleventh Circuit's viewpoint any less appealing. *Cf. Teweleit v. Hartford Life & Accident Ins. Co.*, 43 F.3d 1005, 1010 (5th Cir. 1995)("The [1989] amendment did not change existing law but clarified and emphasized the original Congressional intent behind COBRA.").

age."[8] H.R. Rep. No. 99-241, pt. 1, at 44 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 622. Consistent with this goal, COBRA confers upon displaced employees a chance to locate replacement insurance without suffering any lapse in coverage, but it also allows employers to cancel continuation benefits whenever the purpose underlying the statute is served. Specifically, COBRA authorizes the termination of continuation coverage on the day that a former employee becomes a beneficiary under "any other group health plan," 29 U.S.C. § 1162(2)(D)(i), and we think it is largely irrelevant under the Act whether the employee obtained that coverage before or after his COBRA rights are activated.[9] *Cf. Lutheran Hosp.*, 51 F.3d at 1315 (Coffey, J., dissenting)("The goal of COBRA . . . is to provide temporary health insurance to those people whose jobs are voluntarily or involuntarily terminated, and are without health insurance other than COBRA coverage. COBRA insurance is not, nor has it ever been intended to provide adjunct or double health insurance coverage for those who are covered under another pre-existing policy.")

[8] Of course, to the extent a person has no group health insurance independent of that required by COBRA, the statute does offer him the right to preserve the status quo of his health insurance. *See Lutheran Hosp.*, 51 F.3d at 1317 (Coffey, J., dissenting).

[9] In reaching an opposite result, both the Seventh and Tenth Circuits relied, in varying degrees, upon COBRA's instruction that continuation benefits be "identical to the coverage provided under the [employer's] plan to similarly situated beneficiaries under the plan." 29 U.S.C. § 1162(1); *see Lutheran Hosp.*, 51 F.3d at 1313; *Oakley*, 890 F.2d at 1133. With respect, we fail to see how this requirement, which prevents an employer from offering less favorable insurance to subscribers who invoke their continuation rights, impacts COBRA's termination clauses. True, continuation coverage must be indistinguishable from the insurance offered to other plan beneficiaries, but an employer is still allowed to cancel this coverage whenever a recipient of continuation benefits becomes "covered under any other group health plan." 29 U.S.C. § 1162(2)(D)(i); *see also Lutheran Hosp.*, 51 F.3d at 1317 n.4 (Coffey, J., dissenting)(questioning the Seventh Circuit's reliance on the "identical coverage" requirement).

To be sure, the exception under discussion permits early cancellation of benefits only when the employee "first becomes, after the date of the election," 29 U.S.C. § 1162(2)(D), covered under any other group health plan. Like the Eleventh Circuit, though, we do not consider this clause to be an impediment to the conclusion we reach today. The quoted language was not meant to absolutely insulate from the exception persons who enjoy preexisting insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent. In other words, it is only *after* the election date that an employee's status as a beneficiary under another group health plan will permit the termination of COBRA benefits. *See National Cos.*, 929 F.2d at 1570 ("[I]t is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect."). To use this case as an example, the first time, *after the date of election*, that James Geissal became covered under his wife's plan with TWA was the very moment after the election date. As a consequence, it was well within Moore's rights to cancel James's COBRA benefits unless there was "a significant gap between the coverage afforded under [Moore's] plan and his preexisting plan." *Id.* at 1571. It is now incumbent upon us to decide whether such a significant gap was, in fact, present.[10]

[10] The significant gap test finds at least implicit support in the legislative history accompanying the 1989 amendments to ERISA. In that year, Congress clarified that an employee who obtains insurance under another group health plan is nonetheless entitled to continuation benefits if his additional coverage "contain[s] any exclusion or limitation with respect to any preexisting condition of such beneficiary." 29 U.S.C. § 1162(2)(D)(i). The House Ways and Means Committee reported that this extra language was tailored to effectuate the purpose of continuation coverage, "which was to reduce the extent to which certain events, such as the loss of one's job, *could create a significant gap in health coverage*." H.R. Rep. No. 101-247, at 145 (1989) (emphasis added), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2923. One example of a gap in coverage "occurs when the new employer group health coverage excludes or limits coverage for a preexisting condition that is covered by the continuation coverage." *Id.*

In ascertaining the existence of a significant gap in coverage, our first order of business is to determine what considerations should guide this inquiry. Immediately following the inception of the "gap" test, courts tended to evaluate the issue by fixating upon the actual expenses incurred by the employee as a result of the COBRA cancellation. *See, e.g., McGee*, 17 F.3d at 1126 (mentioning, in dicta, that over $6,500 in personal liability caused by termination of COBRA benefits would constitute a significant gap); *National Cos.*, 929 F.2d at 1571 (explaining that a significant gap would occur where an employee, "despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment"). With the passage of time, however, this methodology has been criticized as representative of an inappropriate *post hoc* determination which gives too little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted. *See, e.g., Lutheran Hosp.*, 51 F.3d at 1317 (Coffey, J., dissenting)("Both the district court and the majority agree that we should not engage in *post hoc* determinations of insurance policies and their coverage. Rather, the policies must be assessed at the time that a person has the right to elect COBRA benefits because of termination of employment."); *Schlett v. Avco Fin. Servs., Inc.*, 950 F. Supp. 823, 833 (N.D. Ohio 1996)("The *post hoc* position advocated by Plaintiffs . . . subjects the employer to an unacceptable degree of uncertainty as to its legal obligations."); *Taylor v. Kawneer Co. Comprehensive Med. Expense Plan for Salaried Employees*, 898 F. Supp. 667, 677 (W.D. Ark. 1995)("[W]e . . . have serious doubts that the mere existence of financial liability for medical expenses in and of itself qualifies as a significant gap in coverage.").

Upon reflection, and with the benefit of several years of case law developing the relevant standard, we agree that placing primary significance upon an employee's actual expenses is unhelpful to those who must administer ERISA plans and does

not adequately encompass other factors which have greater bearing on the presence of a significant gap. Therefore, we eschew this analysis in favor of a framework which, in our opinion, is less dependent upon hindsight and more responsive to the concerns which motivated Congress to enact COBRA. We believe a district court confronted with this question should measure the gap by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election. To adjudge whether a significant gap existed on that date, thus entitling the employee to continuation coverage, the court should examine the policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may foreseeably require." *Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)(quotation and emphasis omitted); *see also Schlett*, 950 F. Supp. at 833 ("[A] significant gap exists when coverage is excluded or limited for certain types of conditions or treatments, when viewed, at the time of election, in light of the benefits offered, preexisting condition exclusions, and the treatment the beneficiary may foreseeably require.").

In this case, Geissal has failed to carry her burden of proving there was a significant gap between the Moore and TWA plans. Based on the record before us, it is impossible for us to conclude that, on the election date, the TWA plan offered appreciably fewer benefits, excluded claims for any of James's preexisting ailments, or limited coverage for treatment likely necessary for a cancer patient in James's condition. To the contrary, it appears that TWA's insurance, while not completely identical to the Moore plan, provided comprehensive medical benefits to employees and their eligible dependents. Indeed, Geissal has satisfactorily identified only two differences between the plans: TWA's yearly deductible was $350 greater than the annual deductible under Moore's program, and the two plans had

separate lifetime maximums on benefits.[11] These rather insubstantial dissimilarities fall far short of the quantum of proof necessary to demonstrate a significant gap in coverage. *Cf. Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)("With respect to any dollar caps on coverage (all that really is at issue here), the 'gap' (if any) must be significant enough to alert a reasonable person of the potential for substantial personal liability under the new plan, that does not exist under the old." (quotation omitted)). Because James was insured under a comparable group health program, the Plan did not violate COBRA when it deemed him ineligible for continuation benefits.

We offer one final comment before proceeding to the remaining issue in this appeal. As the preceding discussion all too clearly illustrates, the federal courts have experienced significant difficulty in attempting to grasp the true meaning of 29 U.S.C. § 1162(2)(D)(i). Our efforts, though unquestionably well intentioned, have inevitably led to at least two separate and irreconcilable interpretations of the law. This deepening rift is extremely troublesome to us, especially given the proliferation of group health plans and the importance of guaranteeing equivalent protection to all ERISA beneficiaries throughout this nation. Accordingly, we suggest that some definitive action, originating either from Congress or the Supreme Court, might be appropriate.

B. Equitable Estoppel

Geissal also contends that the Plan is estopped from denying continuation coverage to James. For a considerable length of time, the availability in ERISA actions of this federal common law doctrine was an open question in our Circuit, *see, e.g.*,

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[11] Curiously, the record does not contain copies of the respective insurance policies.

Jensen v. SIPCO, Inc., 38 F.3d 945, 953 (8th Cir. 1994)("[W]e have left open the question whether equitable estoppel will ever give rise to an ERISA claim . . . ."), *cert. denied*, 115 S. Ct. 1428 (1995), but we recently confirmed that "[c]ourts may apply the doctrine of estoppel in ERISA cases only to interpret ambiguous plan terms," *Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996). The seminal issue in this appeal involves the Plan's interpretation and application of COBRA's continuation coverage provisions, statutory terms which are automatically included within every ERISA plan. *See* 29 U.S.C. § 1161(a) ("The plan sponsor . . . shall provide . . . continuation coverage under the plan."). It is safe to say that reasonable persons could come to conflicting conclusions regarding the import of these COBRA provisions, as the meaning of the statute has fairly evenly divided the federal courts of appeals that have addressed the question. *See National Cos.*, 929 F.2d at 1572 ("[T]he meaning and effect of COBRA's and the Tax Reform Act's amendments to ERISA is something about which reasonable persons can differ."). In the current appeal, then, Geissal challenges the Plan's interpretation of ambiguous components of an ERISA policy, and she has thus presented a cognizable claim of equitable estoppel. *See id.*

The principle of estoppel precludes a party from denying a representation upon which another person has reasonably and detrimentally relied. *See Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 659 (8th Cir. 1992). According to Geissal, the Plan assured James that he was entitled to continuation coverage, and he relied on the Plan's representations by neglecting to obtain other insurance and by choosing not to pursue various legal remedies against his former employer. Geissal's claim founders, however, because she has not adverted to facts establishing that James's alleged reliance was detrimental. To succeed on an equitable estoppel claim premised upon foregone insurance coverage, a plaintiff must demonstrate that alternative insurance was available. *See Smith v. Hartford Ins. Group*, 6 F.3d 131, 137

(3d Cir. 1993)(deciding under similar circumstances that a party proves detrimental reliance by demonstrating that he could have obtained other insurance which covered his illness); *cf. National Cos.*, 929 F.2d at 1574 (discerning detrimental reliance where the plaintiffs "had, in fact, found another insurance company willing to cover [the beneficiary's medical condition]"). Geissal has not made this showing, but has merely proffered a conclusory contention that James surely would have been able to purchase *some* supplemental policy. This is insufficient to withstand summary judgment. *See Smith*, 6 F.3d at 137.

Likewise, Geissal has not shown that James suffered a concrete injury attributable to his failure to seek legal redress based on the termination of his employment. It is not enough to assert, as Geissal has, that James "felt Moore had been very unfair in discharging [him]," Geissal's App. at 23, and that he "gave some thought to whether [he] should consult with an attorney to investigate and to determine what rights and claims [he] might have [had] against Moore," *id.* Instead, as an absolute minimum to overcome summary judgment, an estoppel plaintiff must point to some facts which indicate that the lost causes of action were meritorious. Geissal has not even begun to satisfy this burden, for the record before us is completely bereft of any materials detailing the nature of James's employment with Moore or the circumstances surrounding his discharge. Consequently, because Geissal has not substantiated her allegations of detrimental reliance, we hold that the district court was correct in summarily dismissing the equitable estoppel claim.

III. CONCLUSION

The Plan did not violate COBRA when it terminated James's continuation insurance coverage, and the record does not support Geissal's contention that the Plan should be equitably estopped from denying coverage. As such, we affirm the district court's entry of partial summary judgment for the Plan.

AFFIRMED.

A true copy.

Attest:

CLERK, U. S. COURT OF
APPEALS, EIGHTH CIRCUIT.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 96-2285 EMSL

Bonnie L. Geisal, etc.,
Appellant,

vs.

Moore Medical Corporation, et al.,
Appellees.

Order Denying Petition for Rehearing
and Suggestion for Rehearing En Banc

The suggestion for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

July 30, 1997

Order Entered at the Direction of the Court:
/s/ Michael E. Gans
Clerk, U.S. Court of Appeals, Eighth Circuit

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DDN

BONNIE L. GIESSAL,[1]
Plaintiff,

v.

MOORE MEDICAL CORP., et al.,
Defendants.

[Filed: March 19, 1996]

MEMORANDUM

This matter is before the Court upon the plaintiff's motion for partial summary judgment (Doc. No. 20). The parties have consented to the jurisdiction to the United States Magistrate Judge pursuant to 28 U.S.C. § 636(c).

This case involves the continuation coverage provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. § 1001 *et seq.* Plaintiff is Bonnie L. Geissal, wife and personal representative of the estate of James W. Geissal, who is now deceased. Defendants are Moore Medical Corporation, Group Benefit Plan of Moore Medical Group and Herbert Walker. On plaintiff's motion, Sedgwick Nobel Lowndes, originally named as a defendant, was dismissed without prejudice by order of the Court on November 8, 1994.

[1] Upon the death of plaintiff James W. Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted on November 1, 1995, as party plaintiff. Fed. R. Civ. P. 25(a). References to plaintiff in the masculine in this Memorandum are to decedent.

Count I alleges that defendants violated COBRA by failing to provide continuation insurance coverage once Moore terminated Geissal's employment. Count II alleges that defendants are estopped from denying coverage because at the time of Geissal's termination, defendants made misrepresentations that made him believe that he was entitled to COBRA continuation and would have insurance coverage. Plaintiff alleges that Geissal relied on these representations and continued to pay the amount required for COBRA continuation. Count III alleges waiver, in that, by accepting Geissal's payments, defendants waived any differing construction or interpretation of ERISA plan documents. Count IV, which is not the subject of the pending motion, alleges that Herbert Walker, as plan administrator, failed to provide requested plan documents as required by statute.

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage.

The following facts are without dispute:

FACTS

1. On July 16, 1993, Moore Medical Corp. (Moore or Moore Medical) terminated James Geissal. (Geissal Affidavit, filed June 5, 1995, at ¶ 8; Defendants' Answer, filed July 28, 1994.) At the time of his termination, Geissal was 62 years old and had cancer. (Geissal Aff. at ¶¶ 2, 5.) During his employment at Moore, Geissal was a participant in a health benefits plan, the Group Benefit Plan of Moore Medical Corp., sponsored by Moore for its employees. (Geissal Aff. at ¶ 4; Complaint at ¶ 9; Answer at ¶ 9.)

2. Moore Medical Corp. is an employer and the plan sponsor, within the meaning of 29 U.S.C. § 1102(5) and (16)(B), of defendant Group Benefit Plan (Plan) of Moore Medical Corp. The plan is an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1). Defendant Group Benefit Plan of Moore

Medical Corp. provides for the payment and reimbursement to plan participants of various medical expenses and is a group health plan as defined 29 U.S.C. § 1167(1). (Complaint at ¶¶ 3, 4; Answer at ¶¶ 3, 4.)

3. While Geissal was employed at Moore, his wife, Bonnie, was employed by Trans World Airlines (TWA). (Complaint at ¶ 11; Answer at ¶ 11; Geissal Aff. at ¶ 6.) By reason of Bonnie Geissal's employment at TWA, James Giessal was a covered dependent eligible for coverage under the health insurance policy issued by Aetna Life Insurance Company, which was the health provider or third-party administrator under the TWA plan provided by TWA for its employees. (Geissal Aff. at ¶ 6, 15.) Geissal's coverage through his wife's plan preceded Geissal's termination by Moore. (Complaint at ¶ 11.)

4. Upon Geissal's termination at Moore Medical, Geissal received a notice of his right under COBRA to continue health insurance coverage under Moore's benefit plan. He accepted Moore's offer and elected to continue receiving group health coverage under Moore's Plan. He began making premium payments. (Geissal Aff. at ¶ 14.) The defendant accepted the payments. Approximately six months after his termination, by letter dated January 27, 1994, defendants informed Geissal that they had determined he was not entitled to COBRA coverage because he was already covered under a group policy with Aetna. (Geissal Aff. at ¶ 15.) Geissal was told that the premiums he had already paid would be returned and that those who provided him with medical care during that period would not be paid by the Plan and their billings would be returned to those who had provided medical care to him. (Geissal Aff. at ¶ 15.)

5. Moore's plan had an annual deductible of $150. It also provided for a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 5.) TWA's plan through Aetna had an annual deductible of $500 per year per person and also provided a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 6.)

6. At the time Geissal was terminated, he requested and received a service letter pursuant to Missouri Rev. Stat. § 290.140. (Geissal Aff. at ¶¶ 8, 10b.) At the time he was terminated, he considered whether he should consult an attorney to investigate what rights and claims he might have against Moore because he felt he was unfairly terminated. (Geissal Aff. at ¶ 10.) Geissal decided not to do so, because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶ 10a.) Moore representatives encouraged him to make the COBRA election, which did much to assuage his feelings about his discharge. (Geissal Aff. at ¶ 10b.) At about this time, and shortly after the issuance of the service letter, the Plan or its reinsurer were making large payments for medical care provided to Geissal prior to his termination. (Geissal Aff. at ¶ 10c.) Because he was offered the COBRA continuation coverage, Geissal did not look for another insurance carrier. (Geissal Aff. at ¶ 11.)

DISCUSSION

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage. Plaintiff states that Counts I II and III are related to that issue. However, plaintiff has not argued the issue of waiver, which is the basis for Count III. Plaintiff states that a finding of liability on Count I would moot Counts II and III.

This Court must grant summary judgment if, based upon the pleadings, admissions, depositions and affidavits, there exists no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corporation v. Catrett*, 477 U.S. 317, 322 (1986); *Board of Education. Island Trees Union Free School Dist. v. Pico*, 457 U.S. 853, 863 (1982). The moving party must initially demonstrate the absence of an issue for trial. *Celotex Corporation*, 477 U.S. at 323. Any doubt as to the existence of a material fact must be resolved in favor of the party opposing the motion. *Board of Education v. Pico*, 457 U.S. at 863.

Nevertheless, once a motion is properly made and supported, the non-moving party may not rest upon the allegations in his pleadings but must instead set forth specific facts showing that there is a genuine issue of material fact for trial. Fed. R. Civ. P. 56(e); *Buford v. Tremayne*, 747 F.2d 445, 447 (8th Cir. 1984). Summary judgment must be granted to the movant if, after adequate time for discovery, the non-moving party fails to produce any proof to establish an element essential to the party's case and upon which the party will bear the burden of proof at trial. *Celotex Corporation*, 477 U.S. at 322-24.

In response to the motion, defendants have raised several issues. First, defendants argue that the plaintiff lacks standing to maintain the instant lawsuit because plaintiff has no economic damages. Based upon the discovery supplied by plaintiff and Aetna, which was the group insurance carrier under the spouse's preexisting health benefit plan, defendants assert that all of plaintiff's medical bills for "covered expenses" during the relevant period were paid by Aetna. Therefore, defendants claim, plaintiff has no claim for compensatory damages or other type of damages because he has suffered no damages. The Court nevertheless concludes that plaintiff has standing to bring this lawsuit for relief other than compensatory damages. *See* 29 U.S.C. § 1132(a)(1).

Second, defendants argue that a necessary party needed for complete adjudication pursuant to Federal Rule of Civil Procedure 19(a) is not before the Court. Defendants argue that the real party in interest is Aetna, the health provider for the TWA plan, and TWA, Bonnie Geissal's employer. Defendants argue that the question is whether Moore or Aetna should pay for the covered medical expenses during the COBRA continuation period. Defendants argue that if the Court were to hold that Moore should have provided COBRA coverage to Geissal and that such policy was primary to Aetna's policy, then Aetna should be reimbursed by Moore for all "covered expenses"

incurred by Geissal during the COBRA period. Further, the plaintiff would owe the Moore health plan $2,673.18 for 18 months of COBRA coverage. They argue that there is a possibility of a double recovery for plaintiff.

Plaintiff, in response, argues that defendants have waived the defense of failure to join a necessary party. However, because this defense can be raised as an issue at a trial on the merits, *see* Federal Rule of Civil Procedure 12(h)(2), the question of whether there is a genuine issue for trial with regard to this defense can appropriately be raised on a motion for summary judgment. *See Kornblum v. St. Louis County*, 48 F.3d 1031, 1038 (8th Cir.), *opinion vacated on other grounds*, 72 F.3d 661 (8th Cir. 1995).

The question of whether a party must be joined is examined under Federal Rule of Civil Procedure 19(a), which states in pertinent part:

> A person who is subject to service of process and whose joinder will not deprive the court of jurisdiction over the subject matter of the action shall be joined as a party in the action if (1) in the person's absence complete relief cannot be accorded among those already parties, or (2) the person claims an interest relating to the subject of the action and is so situated that the disposition of the action in the person's absence may (i) as a practical matter impair or impede the person's ability to protect that interest or (ii) leave any of the persons already parties subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations by reason of the claimed interest.

Aetna is not a necessary party under the first subsection of Rule 19(a), because complete relief may be granted between Moore and plaintiff without Aetna's joinder. Moore may be required to continue coverage, in consideration for premiums paid. Because Aetna has already paid claims, its joinder is not necessary in order for plaintiff to obtain relief from Moore.

Therefore, defendants must rely on Rule 19(a)(2), which requires a finding that Aetna "claims an interest relating to the subject matter of the action." Assuming that Aetna "claims" such an interest, the remaining requirements of Rule 19(a)(2) are not met. Aetna's absence from this case will not impair or impede its ability to protect that interest. If the Court decides that Moore should have provided COBRA coverage, Aetna could decide what future recourse, if any, to take. The possibility of potential litigation is irrelevant to the criteria of Rule 19. "The focus is on relief between the parties and not on the speculative possibility of further litigation between a party and an absent person." *LLC Corp. v. Pension Benefit Guaranty Corp.*, 703 F.2d 301, 305 (8th Cir. 1983). In addition, a determination of the case in the absence of Aetna will not subject Moore to the risk of inconsistent or double obligations.

Third, defendants argue that the Court cannot grant relief against them unless it finds that the Moore health plan was primary to the Aetna health plan. This determination can be made upon adequate discovery, without Aetna's presence as a party.

The cardinal issue between the present parties is whether James Geissal's preexisting (Aetna) insurance coverage made him ineligible for continuation coverage with the Fund upon his termination. The resolution of that issue is one of statutory interpretation. ERISA, as amended by the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. § 1161-1168, requires employers to offer continuation coverage to certain categories of departing employees. COBRA specifies the circumstances which entitle an employer to terminate continuation coverage. The termination provision at issue in this case is as follows:

> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

* * *

> (D) The date on which the qualified beneficiary first becomes, after the date of the election—
>
> (i) covered under any other group health plan (as an employee or otherwise) 'which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.'

29 U.S.C. § 1162(2)(D)(i).

Plaintiff argues that the plain language of the statute mandates that only other group coverage which is obtained *after* the date of the election can preclude COBRA entitlement and selection. Therefore, because Geissal's coverage under his wife's plan existed *before* he elected the COBRA continuation plan, plaintiff argues that James Geissal is entitled to continuation coverage under the Moore Plan.

In interpreting a statute, a Court is required to look to the plain language of the statute, give significance to the statute as a whole, and to examine the purpose and intent of a statute when deciding what its terms mean. *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *Richards v. United States*, 369 U.S. 1, 11 (1962); *National Labor Relations Board v. Lion Oil Co.*, 352 U.S. 282, 289-90 (1957); *United States Department of Health and Human Services v. Smith*, 807 F.2d 122, 126-27 (8th Cir. 1986).

Five Circuit Courts of Appeals have considered whether COBRA authorizes an employer to withhold continuation coverage when the departing employee has dual coverage throughout his employment and therefore has a continuing source of coverage when he resigns or is terminated. *See Lutheran Hospital of Indiana, Inc. v. Business Men's Assurance Co. of America*, 51 F.3d 1308 (7th Cir. 1995); *McGee v. Funderberg*, 17 F.3d 1122 (8th Cir. 1994); *National Companies Health Benefit Plan*

v. St. Joseph's Hospital, Inc., 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).

The Tenth Circuit was the first circuit to address the issue in *Oakley*.[2] At the time of plaintiff's termination, he had insurance under his employer and was also a dependent under his wife's group health plan. However, his wife's plan, unlike his employer's plan, did not cover the costs of the medical treatment he needed. The court found that the plain meaning of the statute "cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage." *Oakley*, 890 F.2d at 1132. The court read the language of subsection (i) to refer to other coverage occurring *after* the qualifying event. *Id.* (emphasis added).

In Brock, the plaintiff elected continuation coverage when she was terminated. Both before and after her termination, she also was covered as a dependent on her husband's group health insurance plan. The Fifth Circuit held that plaintiff was not entitled to continuation coverage under COBRA. *Brock*, 904 F.2d at 297.

In *National Companies*, the plaintiff elected, upon his resignation, to continue receiving group health coverage under his employer's plan. Both before and after his resignation, he was also covered under the group health plan of his wife's employer. Plaintiff had paid premiums and the premiums were accepted. The Eleventh Circuit held that an ERISA provider is not required to offer continuation coverage to an employee or his dependents who are covered under a preexisting group health plan. *National Companies*, 929 F.2d at 1566. The court held that

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[2] The actual provision at issue in *Oakley* was 42 U.S.C. § 300bb-2(2)(D)(1), which covers public employees. However, it is identical to the provision at issue in this case.

> it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date. In effect, such an employee is ineligible for continuation coverage.

Id. at 1570.

In *McGee*, the plaintiff's deceased husband had health insurance as a benefit of his membership in a union. Upon his retirement, he elected continuation health coverage under COBRA and paid his monthly premiums. When he was diagnosed with cancer and began submitting claims for payment of medical expenses, the Fund terminated COBRA coverage on the basis that he was covered by another group health care plan. *McGee*, 17 F.3d at 1123. The district court adopted the rationale of the Eleventh Circuit in *National Companies*. On appeal, the Eighth Circuit found the Eleventh Circuit's reasoning "attractive," but concluded that it need not decide the question of whether preexisting coverage defeated the employee's eligibility for continuation coverage. *Id.* at 1124.

In *Lutheran*, plaintiff was covered under both her employer's and her husband's group health plans. Plaintiff had a neurological disorder. She was then laid off. Her employer's insurance company told her she would not be eligible for COBRA coverage because of her preexisting coverage under her husband's plan. *Lutheran*, 51 F.3d at 1310 & n.1. The court held that the clear language of the statute provides that an employee loses the right to continuation coverage only if he chooses after the election date to accept coverage under another group health plan. *Id.* at 1312. Therefore, preexisting coverage would not make an employee ineligible for COBRA coverage. "The statutory dis-

tinction between preexisting and after-acquired health care coverage is reasonable and facilitates the preservation of the beneficiary's health care status quo." *Id.*

The undersigned finds the reasoning of the Eleventh Circuit persuasive and therefore holds that James Geissal's preexisting coverage under his wife's plan constitutes coverage "under any other group health plan" for purposes of 29 U.S.C. § 1162(2)(D)(i).

The fact that Geissal had other coverage is not entirely dispositive, however. According to the plain language of the statute, if the other coverage contains an "exclusion or limitation with respect to any preexisting condition of [the] beneficiary," the employee may be eligible for continuation coverage.

The question is whether there was a gap between the coverage offered by the employer and that offered by the other insurance. Circuit Courts of Appeal have examined the relative coverage available to the beneficiary under both plans.

In *Oakley*, the plaintiff sought coverage for rehabilitation therapy for a brain injury. This treatment was covered under the plan provided by his former employer but was not covered under his spouse's plan. *Oakley*, 890 F.2d at 1130. The court held that plaintiff's coverage under his spouse's plan did not render him ineligible for continuation coverage from his former employer. In dicta, the Tenth Circuit noted that there was a gap between plaintiff's coverage under his employer's plan and his coverage under his wife's plan. *Id.* at 1133. The court noted that "the facts of this case illustrate the precise gap in coverage which troubled Congress;" in other words, forcing the plaintiff's family to pay for the treatment of his catastrophic injury would put plaintiff and his family at risk and jeopardized his treatment. *Id.* at 1133.

In *Brock*, the Fifth Circuit held that preexisting coverage rendered a departing employee ineligible for continuation coverage. However, the court also noted that there was no "gap" in plaintiff's coverage under the two plans. Specifically, the court noted that plaintiff was covered under both plans for the type of medical problem for which she later claimed benefits. *Brock*, 904 F.2d at 297.

The Eleventh Circuit showed a similar concern in *National Companies* when it examined the character of plaintiff's coverage under his former employer's plan and under his spouse's preexisting plan. *National*, 929 F.2d at 1571. While the court held that an employer was not required to provide continuation coverage to an employee who was covered under a preexisting group health plan, it also held that an employee may be entitled to receive continuation coverage under his previous employer's plan, if there is a significant gap between the employer's plan and the preexisting plan. *Id.* at 1571. If there is a significant gap in coverage such that the employee would become personally liable for substantial medical expenses to his family's detriment, the employee would not truly be "covered" under the preexisting plan. *Id.* The court noted that Congress' purpose in enacting COBRA was to respond to "the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." *National*, 929 F.2d at 1567 (quoting H.R. Rep. No. 241, 99th Cong., 2d Sess. 44, *reprinted in* 1986 U.S.C.C.A.N. 579, 622). The court concluded that denial of continuation coverage when the employee's only other coverage does not truly cover the employee would frustrate Congress' intentions. *Id.*

In *McGee*, the Eighth Circuit noted in dicta that a significant gap between coverage afforded under the employer's plan and that afforded under the preexisting plan would entitle plaintiff to COBRA coverage. *McGee*, 17 F.3d at 1126. The court quoted *National* for the proposition that when a gap in coverage exists, then the employee is not truly covered by the preexisting group

health plan. *Id.* The court found that there was a significant gap because plaintiff remained personally liable for more than $7,500 under the preexisting plan, while under her employer's plan she would have been personally liable for only $1,000 in medical expenses. *Id.*

In this case, plaintiff maintains that there is a significant gap between the coverage provided by Moore and that provided by the preexisting plan because (1) Moore's plan had an annual deductible of $150 for covered medical services and treatments that Geissal needed, while Aetna's plan had an annual deductible of $500 per year per person; (2) Moore's plan had a lifetime maximum only as to payments made by the Plan and Aetna's plan had a lifetime maximum as to payments made by Aetna; therefore, before his termination Geissal had the benefit of two maximums; (3) coverage of some kinds of care were different, with coverage under Moore's plan being more extensive. (Affidavit of James Geissal, filed June 5, 1995, at ¶¶ 5-7.)

Plaintiff does not allege that James Geissal suffered from a preexisting condition that was not covered under Aetna's plan. Plaintiff does not allege that Geissal's condition was not covered by Aetna. Although the record is unclear about the exact amount of benefits paid or the extent of coverage, there is no dispute that benefits were in fact paid. The only difference between the two policies that Geissal asserted in his affidavit is the amount of deductible. This is not a significant gap. *See National*, 929 F.2d at 1571. A significant gap in coverage exists when coverage is excluded or limited for certain types of conditions or treatments. *See, e.g., Brock v. Primedica, Inc.*, 904 F.2d 295, 297 (5th Cir. 1990). Plaintiff has provided no evidence that coverage under the TWA plan was excluded or limited for Geissal's condition.

Plaintiff argues that, even if Moore was not required to provide continuation coverage to James Geissal, it is estopped from denying such coverage. *See National*, 929 F.2d at 1571-74.

Plaintiff alleges a federal common law claim of estoppel in Count II.[3]

The elements of equitable estoppel, as defined by federal common law, are that (1) the party to be estopped misrepresented material facts; (2) the party to be estopped was aware of the true facts; (3) the party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it; (4) the party asserting estoppel did not know, nor should it have known, the true facts; and (5) the party asserting the estoppel reasonably and detrimentally relied on the misrepresentation. *Heckler v. Community Health Services, Inc.*, 467 U.S. 51, 59 (1984); *National*, 929 F.2d at 1572; *United States v. Aetna Casualty & Surety Co.*, 480 F.2d 1095, 1099 (8th Cir. 1973).

Plaintiff argues that Geissal was offered continuation coverage, (Aff. at ¶¶ 10b, 12) and that he relied upon that offer to his detriment. (Aff. at 10, 11). He stated that he did not look for other insurance, knowing how weak TWA was financially and how he needed more than what TWA provided, and he did not pursue investigation as to defendants' possible misconduct in terminating him.

In *National*, the court found that the employer had misrepresented to plaintiff that he was entitled to and would receive continuation coverage, in a memorandum explaining continuation coverage; that by accepting premium payments for four months, the company continually assured plaintiff that the Plan was providing him with coverage; that Plan representatives knew or believed, prior to plaintiff's resignation, that plaintiff

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[3] The Eighth Circuit has not recognized a federal common law action for equitable estoppel, although it has been suggested that it would do so in certain circumstances. *Slice v. Sons of Norway*, 34 F.3d 630, 633-34 (8th Cir. 1994); *Coonce v. Aetna Life Insurance Co.*, 777 F. Supp. 759, 769-70 (W.D. Mo. 1991). *See also McGee*, 17 F.3d at 1126.

was ineligible for continuation coverage because of his preexisting coverage; that plaintiff relied on the company's memorandum notifying him of his rights with respect to continuation coverage; that plaintiff was unaware of the true facts because there was no evidence that plaintiff knew he was not entitled to continuation coverage; and that plaintiff relied on those representations by deciding not to accept coverage under another policy when he learned he would be entitled to continuation coverage. In addition, plaintiff incurred personal liability for $6,700 in medical expenses he would not have incurred had he maintained dual coverage. *National*, 929 F.2d at 1573-74.

In *McGee*, McGee elected, upon retirement, to continue coverage and he paid monthly premiums. When he was diagnosed with cancer and began to submit claims for payment of medical expenses, his employer's plan terminated COBRA coverage. *Id.* at 1123. McGee continued to tender premium payments until he died, but the Fund refused to accept the payments. *Id.* The Eighth Circuit indicated in dicta that the doctrine of equitable estoppel might be applicable to such a case, in which the employer's plan accepted the employee's premiums for months, denied coverage when he became sick, and he relied to his detriment on the Fund's representations that COBRA coverage would be afforded. *McGee*, 17 F.3d at 1126.

In this case, there is no dispute that defendants told Geissal he was entitled to continuation coverage. In addition, defendants accepted Geissal's premium payments for about six months, from the date of termination, July 16, 1993, until he was notified on January 27, 1994, that Moore had determined he was not entitled to COBRA coverage. There is no evidence that Plan representatives previously knew he was covered by a preexisting policy. However, the Court will assume that the defendants had constructive knowledge because of their obligation to know every ERISA provision and to determine employees' rights. *National*, 929 F.2d at 1573 n.15. There is no dispute that Geissal

relied on the company's notification that he was entitled to continuation coverage. There also is no dispute that Geissal was unaware of the true facts, *e.g.*, that the preexisting policy disqualified him from COBRA coverage.

However, while plaintiff asserts that Geissal relied on those representations, there is no evidence that he relied on them to his detriment. Plaintiff has not shown that Geissal suffered any economic loss. *See National*, 929 F.2d at 1574 n.16. Geissal stated that, although he gave some thought to whether he should consult an attorney to investigate what rights and claims he may have had against Moore concerning his termination and he knew that he could complain to government agencies about his termination, he decided not to do so because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶¶ 10 and 10a.) He further stated that Moore representatives encouraged him to make the COBRA election offered by Moore, and that conduct did much to assuage his feelings about his discharge, so much so that he decided against taking any investigative steps beyond requesting a service letter. (Geissal Aff. at ¶ 10b.) Geissal stated that he later learned that, by the time Moore informed him that he was not entitled to COBRA coverage, his termination-related claims were time-barred. (Geissal Aff. at ¶ 16.)

Geissal's statements are insufficient to show detrimental reliance. There is no evidence that Geissal accepted the COBRA coverage as part of an express agreement not to take legal action against Moore concerning his termination. Geissal's statements of inchoate claims are speculative and insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e).

Geissal also states that, had he known he would be limited to coverage only through his wife's policy, he would have looked for additional coverage. (Geissal Aff. at ¶ 11.) This statement is speculative at best concerning the outcome of any such search for other coverage, and the statement is insufficient to withstand

summary judgment. *Smith v. Hartford Insurance Group*, 6 F.3d 131, 137 (3d Cir. 1993); Fed. R. Civ. P. 56(e). This is not a case where Geissal found other insurance coverage but decided not to purchase it because of Moore's representation about COBRA continuation coverage. *See National*, 929 F.2d at 1574.

For these reasons, the plaintiff's motion for partial summary judgment will be denied. The material facts are undisputed and defendants are entitled to judgment on Counts I and II as a matter of law. Therefore, judgment will be entered in favor of the defendants on Counts I and II. *Madewell v. Downs*, 68 F.3d 1030. 1048-50 (8th Cir. 1995).

Count III alleges that the defendants, by accepting Geissal's payments, waived any differing construction or interpretation of plan document. Plaintiff did not move for summary judgment on that ground and the parties have not argued it. The doctrines of waiver and estoppel are distinct. *Karlen v. Ray E. Friedman & Co. Commodities*, 688 F.2d 1193, 1197 (8th Cir. 1982). *See Buder v. Fiske*, 174 F.2d 260, 267-68, *reh'g denied*, 177 F.2d 907 (8th Cir. 1949). Plaintiff also did not seek summary judgment on Count IV.

An appropriate order is issued herewith.

/s/ David D. Noce
UNITED STATES
MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DNN

BONNIE L. GIESSAL,[1]
Plaintiff,

v.

MOORE MEDICAL CORP., et al.,
Defendants.

ORDER

[Filed: March 19, 1996]

In accordance with the Memorandum filed herewith,

IT IS HEREBY ORDERED that plaintiff's motion for partial summary judgment (Doc. No. 20) is denied.

IT IS FURTHER ORDERED that summary judgment is entered for the defendants and against the plaintiff on Counts I and II of the amended complaint. Counts I and II are dismissed.

IT IS FURTHER ORDERED that the parties shall have forty-five days in which to file motions for summary judgment on Counts III and IV.

/s/ David D. Noce
UNITED STATES
MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

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[1] Upon the death of plaintiff James W. Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted as party plaintiff. Fed. R. Civ. 25(a).

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 263 DDN

BONNIE L. GEISSAL as representative of the
Estate of JAMES W. GEISSAL, deceased, etc.
Plaintiff,

v.

MOORE MEDICAL CORP., et al,
Defendants.

ORDER FOR ENTRY OF FINAL JUDGMENT
COUNTS I AND II

On application of plaintiff and without objection of defendants, the Court hereby determines and finds that by reason of the rationale expressed in the Court's memorandum of March 19, 1996 entered in this matter, entering summary judgment in favor of defendants on the Court's own motion on Counts I and II, the Court hereby expressly determines that is no just reason for delay of entry of final judgment in favor of defendants on Counts I and II. The Court hereby directs the Clerk to enter final judgment in favor of defendants on Counts I and II. In the event plaintiff timely appeals from the entry of such judgments, further action on Counts III and IV shall be stayed until disposition of the appeal.

/s/ David D. Noce
United States Magistrate Judge

Dated at St. Louis, MO
April 4, 1996

No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

The essential question in this case is whether an employer is obligated by the Comprehensive Omnibus Budget Reconciliation Act ("COBRA"), 29 U.S.C. § 1161, *et seq.* to provide continuation of a former employee's health insurance when that former employee, both pre and post employment termination, was covered under another group health plan which had no pre-existing condition provision, and there was no significant "gap" in coverage.

PARTIES TO THE PROCEEDINGS BELOW

The parties to the proceedings in the United States Court of Appeals for the Eighth Circuit include:

1. Petitioner Bonnie L. Geissal, as representative of the Estate of James W. Geissal, deceased;

2. Moore Medical Corp., Respondent;

3. Group Benefit Plan Of Moore Medical Corp., Respondent;

4. Herbert Walker, Respondent.

Other than as noted, none of the parties has a parent company or nonwholly owned subsidiary involved in this litigation.

REASONS FOR DENYING THE WRIT

I.

THIS COURT SHOULD NOT GRANT PETITIONER'S PETITION FOR WRIT OF CERTIORARI BECAUSE THE EIGHTH CIRCUIT COURT OF APPEALS CORRECTLY DECIDED THE ISSUE, AND THE ISSUE IS NOT OF SUCH IMPORTANCE WARRANTING REVIEW BY THE UNITED STATES SUPREME COURT.

The Eighth Circuit in its well written and well considered opinion correctly determined the law on COBRA continuation coverage when there is pre-existing spousal coverage. COBRA continuation coverage need only be provided to a former employee when there is a significant gap between the employee's prior coverage and that afforded by the spouse's group health plan. Such clearly was the intent of Congress in enacting the 1989 amendments to the COBRA legislation.

The Eleventh Circuit in *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991), thoroughly addressed the statutory language of COBRA and the intent of Congress. In addressing the 1989 amendment, the court at page 1569 stated:

> This amendment, like the *Oakley* dicta, emphasizes the importance of the character of the coverage obtained by the beneficiary.
>
> Congress enacted COBRA because it was concerned about the fate of individuals who, after losing coverage under their employer's ERISA plan, had no (emphasis added) group health coverage at all.

Moreover, the Eighth Circuit's decision is consistent with the legislative history behind COBRA. As the trial court properly noted, a court is required to look to the plain language of the statute, give significance to the statute as a whole, and examine the purpose and intent. *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *See also In Re Graven*, 936 F.2d 378 (8th Cir. 1991) ("When interpreting a statute we look not only to the express language but also to the overall purpose of the act.")

Congress enacted the 1989 COBRA amendments to ERISA in response to

> reports of the growing number of Americans without **any** (emphasis added) health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay.

Brock v. Primedica, Inc. 904 F.2d 295 (5th Cir. 1990), citing H.R. Rep No. 241, 99th Cong., 2d Sess. 44, reprinted in 1986 U.S.C.C.A.N. 42, 579, 622. Thus, for petitioner to maintain that COBRA supports his attempt to obtain duplicative insurance coverage flies in the face of the Congressional purpose to help those without any coverage. As such, the Court must reject petitioner's strained interpretation.

See also Teweleit v. Hartford Life and Accident Insurance Company, 43 F.3d 1005 (5th Cir. 1995) where the court revisited the law on COBRA continuation coverage. After reviewing the reported cases to date, the court succinctly summarized the status of those cases:

> *Brock* and *National Co.* and, to a lesser extent, *Oakley* have voiced a common interpretive theme of COBRA coverage: its purpose is to eliminate gaps in

> insurance coverage that could accompany changes in or loss of employment. These statements are not just a theme, however, but the enacted will of Congress in language sufficiently clear to achieve its purpose.

Teweleit, supra, at page 1008.

It simply does not take a crystal ball to divine the intent of Congress in enacting COBRA. It wanted short term protection for employees without any or inadequate health insurance while not saddling employers with too great of a cost burden. *See National Co., supra* at pages 1569-1579. In fact, the 1989 amendment increased the situations where a group health plan could terminate COBRA continuation coverage. If Congress were not concerned about the cost burden on employers, it would not have given group health plans the ability to terminate coverage. The court in *Lutheran Hospital*, 51 F.3d 1308 (7th Cir. 1995), failed to take these salient facts into consideration in making its holding.

Contrary to petitioner's protestations, the Eighth Circuit's position is consistent with the intent of Congress and is clearly consistent with the statutory language. The continuation coverage provisions of the Employee Retirement Income Security Act of 1974, more specifically 29 U.S.C. § 1162(2)(D)(i) provides that COBRA coverage can be suspended on:

> The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion

> or limitation with respect to any preexisting condition of such beneficiary.

Under the plain terms of the statute, when a covered individual has other preexisting coverage, his COBRA coverage can be suspended on the day of election. This interpretation does not ignore the plain meaning of any of the statute's terms. Petitioner's interpretation, however, relies on the fallacy that because the statute points to the first date after the date of election to determine suspension of coverage, that coverage must necessarily originate after the election date. This is a complete non-sequitur. The statute only discusses when suspension can occur. It never defines when the other policy must initiate coverage.

Furthermore, if the plain terms of the statute mandate petitioner's interpretation, it is remarkable that four different circuits have ignored this mandate. *See National Companies*, *supra* at 1570. ("Thus, it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does the coverage take effect"); *Lutheran Hospital*, 51 F.3d at 1316 (J. Coffey, dissenting) ("There is nothing in the language of this statute to suggest that termination of the right to COBRA coverage cannot occur simultaneously with the triggering of the right to coverage, if a person continues comparable coverage under a pre-existing health plan.")

For all of the foregoing reasons, respondents respectfully state that the Eighth Circuit Court of Appeals properly decided the instant cause, and the Petition for Writ of Certiorari should be denied.

Moreover, the petitioner has urged the Court to accept this

case for review due to the admitted split of authority among the five circuits that have addressed this issue. Despite petitioner's protestations to the contrary, the issues involved in this case do not warrant review by this Court. The issue in question is extremely limited and narrow. It neither involves such an important question of federal law nor a question of broad ranging applicability that review should be granted. Further, any problems with the COBRA legislation are more properly the providence of Congress. In the fast changing area of health care legislation, Congress will have multiple opportunities to address the instant issue if it sees fit.

CONCLUSION

Certiorari is not warranted. For the reasons set for above, the respondents respectfully request that this Court deny the Petition for Writ of Certiorari.

Respectfully submitted,

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(7)

FILED

NO. 689 MAR 4 1998

In The

Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED OCTOBER 20, 1997
CERTIORARI GRANTED JANUARY 23, 1998

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The following opinions, orders, memoranda and judgments have been omitted in printing this joint appendix because they appear on the following pages in the printed appendix to the petition for writ of certiorari:

APPENDIX A — LIST OF RELEVANT DOCKET ENTRIES

U.S. DISTRICT COURT
EASTERN DISTRICT OF MISSOURI (EASTERN)
CIVIL DOCKET FOR CASE #: 94-CV-1263

Docket as of May 8, 1996:

Date	Proceedings
6/30/94	COMPLAINT; # Waivers of Service Issued: 4 # Counts: 4 # Consents: 5; jury demand (bll) [Entry date 07/01/94]
6/30/94	RECEIPT # 101596 in the amount of $120.00 for filing fee. (bll) [Entry date 07/01/94]
7/21/94	WAIVER OF SERVICE executed upon defendant Group Benefit Plan on 7/21/94 (cla) [Entry date 08/10/94]
7/28/94	ANSWER by defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker to [1-1] (cla) [Entry date 08/01/94]
8/31/94	ANSWER by defendant Sedgwick Noble Lowndes to [1-1] (ddr) [Entry date 09/09/94]
9/9/94	ORDER by Honorable Mary Ann L. Medler The pltff. has fld. the above cause of action. By random assignment, the matter was referred to the undersigned US Magistrate

Appendix A

Judge. Pursuant to my memorandum of 9/8/94 to Robert St. Vrain, I have requested that I not be assigned to any case in which the law firm of Sandberg, Phoenix & Von Gontard represents a party because of potential conflict of interest. Therefore the clerk of the court shall randomly reassign this case. (cc: all counsel) (cla) [Entry date 09/16/94]

9/13/94 ORDER fld. by the Clerk Case reassigned to Honorable David D. Noce (cc: all counsel) (cla) [Entry date 09/16/94]

10/4/94 ORDER SETTING RULE 16 SCHEDULING CONFERENCE by Honorable David D. Noce. Scheduling Conference is set for; In-court hearing 11/3/94 at 1:00 p.m. In advance of date for submission of joint proposed scheduling plan, counsel for parties shall meet to discuss nature of parties claims, etc. No later than 11/1/94, counsel shall file with Clerk of Court (and courtesy copy to chambers) a joint proposed scheduling plan (cc: all counsel) (cjw) [Entry date 10/12/94] [Edit date 11/14/94]

11/3/94 ORDER by Honorable David D. Noce; In-court hearing 11/17/94 at 10 AM. Hrg date of 11/3/94 vacated, for response to court; Resp to court ddl 11/15/94 for Sedgwick Noble Lowndes, for Herbert Walker, for

Appendix A

Group Benefit Plan, for Moore Medical Corp., for James W. Geissal to file joint proposed scheduling plan (cc: all counsel) (jwh) [Entry date 11/08/94] [Edit date 11/14/94]

11/8/94 STIPULATION FOR DISMISSAL OF PARTY-IN-INTEREST defendant Sedgwick Noble Lowndes without prejudice by plaintiff James W. Geissal. SO ORDERED DDN. (cjw) [Entry date 11/15/94]

11/14/94 FULL CONSENT has been received by plaintiff James W. Geissal on 10/6/94, defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker on 11/14/94, defendant Sedgwick Noble Lowndes on 10/11/94 (defendant S.N. Lowndes has been terminated from this case) (seb) [Entry date 11/15/94]

11/14/94 RESPONSE to court JOINT PROPOSED SCHEDULING PLAN by plaintiff James W. Geissal, defendant Moore Medical Corp., defendant Group Benefit Plan, Herbert Walker [9-2] (seb) [Entry date 11/16/94]

11/16/94 ORDER by Honorable David D. Noce granting response [12-1] (cc: all counsel) (jwh) [Entry date 11/21/94]

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1/30/95	MOTION by plaintiff James W. Geissal, defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker, defendant Sedgwick Noble Lowndes to extend discovery deadline to 2/8/95 (jwh) [Entry date 02/02/95]
2/6/95	RULED DOCUMENT by Honorable David D. Noce granting motion to extend discovery deadline to 2/8/95 [14-1] (cc: all counsel) (cjw) [Entry date 02/09/95]
2/16/95	GENERIC SCHEDULING EVENT. terminating resp court ddl of 11/15/94 and in court hrg. of 11/17/94 (cjw)
4/12/95	MOTION by plaintiff James W. Geissal, defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker to amend joint proposed sched plan (jwh) [Entry date 04/14/95]
4/13/95	RULED DOCUMENT by Honorable David D. Noce Parties granted leave to file amended sched plan. (cc: all counsel) (jwh) [Entry date 04/17/95]
4/13/95	AMENDED JOINT PROPOSED SCHEDULING PLAN by plaintiff James W. Geissal, defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker, defendant Sedgwick Noble Lowndes (jwh) [Entry date 04/17/95]

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6/5/95	RULED DOCUMENT by Honorable David D. Noce Pltf granted leave to file memo in support of motion for s/j not to exceed 23 pages. (cc: all counsel) (jwh) [Entry date 06/08/95]
6/5/95	MOTION by plaintiff James W. Geissal for partial summary judgment on issue of obligation of defts to provide Cobra coverage w/memo. (jwh) [Entry date 06/08/95] [Edit date 06/15/95]
6/5/95	AFFIDAVIT of James Geissal re [20-1] (jwh) [Entry date 06/08/95]
6/21/95	MOTION by defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker to stay depos. (jwh) [Entry date 06/22/95]
6/21/95	MOTION by defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker to extend time to respond to pltf's motion for partial sumjgm. (jwh) [Entry date 06/22/95]
6/23/95	RULED DOCUMENT by Honorable David D. Noce granting motion to stay depos. [22-1] (cc: all counsel) (jwh) [Entry date 06/27/95]
6/23/95	RULED DOCUMENT by Honorable David D. Noce granting motion to extend time to

	respond to pltf's motion for partial sumjgm. [23-1] (cc: all counsel) (jwh) [Entry date 06/27/95]
6/30/95	MOTION by defendant Moore Medical Corp., defendant Group Benefit Plan, defendant Herbert Walker to extend time to respond to motion for partial summary judgment to 7/5/95 (jwh) [Entry date 07/06/95]
7/7/95	RULED DOCUMENT by Mag Judge David D. Noce granting motion to extend time to 7/18/95 to respond to motion for partial summary judgment to 7/5/95 [24-1] (cc: all counsel) (cjw) [Entry date 07/11/95]
7/18/95	MOTION by defendants for order for oral argument on pltff's motion for partial summary judgment (lal) [Entry date 07/21/95]
7/18/95	RESPONSE by defendants to motion for partial summary judgment on issue of obligation of defts to provide Cobra coverage w/memo. [20-1] (lal) [Entry date 07/21/95]
7/24/95	ORDER by Mag Judge David D. Noce; the motion of the plaintiffs for summary judgment is set for a hearing on October 20, 1995 at 11:00 a.m.; In-court hearing 10/20/95 (cc: all counsel) (kac) [Entry date 07/25/95]

7/25/95	REPLY by plaintiff James W. Geissal to response to motion for partial summary judgment on issue of obligation of defts to provide Cobra coverage w/memo. [20-1] (jwh) [Entry date 07/26/95]
8/9/95	ORDER by Mag Judge David D. Noce denying motion for order for oral argument on pltff's motion for partial summary judgment [26-1] (cc: all counsel) (jwh) [Entry date 08/15/95]
9/25/95	ORDER by Mag Judge David D. Noce; In-court hearing 10/20/95 at 3:00 on pltf's motion for sum/jgm. Reset from 11:00 (cc: all counsel) (jwh) [Entry date 09/29/95]
11/1/95	MOTION by plaintiff James W. Geissal to substitute party to Bonnie L. Geissal as Personal Representative of the Estate of James W. Geissal, deceased (kac) [Entry date 11/06/95]
11/1/95	RULED DOCUMENT by Mag Judge David D. Noce granting motion to substitute party to Bonnie L. Geissal as Personal Representative of the Estate of James W. Geissal, deceased [32-1]; dismissing plaintiff James W. Geissal and substituting plaintiff Bonnie L. Geissal (cc: all counsel) (kac) [Entry date 11/06/95]

3/19/96	ORDER (with memorandum) by Mag Judge David D. Noce denying motion for partial summary judgment on issue of obligation of defts to provide Cobra coverage w/memo. [20-1]. FURTHER ORDERED that summary judgment is entered for the defts' and against the pltf. on Counts I and II of the amended complaint. Counts I and II are dismissed. FURTHER ORDERED that the parties shall have 45 days in which to file motions for summary judgment on Counts III and IV.; Resp to court ddl 5/3/96 (cc: all counsel) (lgn) [Entry date 03/22/96]
4/4/96	MOTION by plntf Bonnie L. Geissal to enter final judgments on summary judgment rulings on Counts I & II & for determination of no just reason to delay entry of judgment on Counts I & II (kms) [Entry date 04/10/96] [Edit date 04/10/96]
4/4/96	ORDER by Mag Judge David D. Noce granting motion to enter final judgments on summary judgment rulings on Counts I & II for determination of no just reason to delay entry of judgment on Counts I & II [34-1] In the event plaintiff timely appeals from the entry of such judgments, further action on Counts III and IV shall be stayed until disposition of the appeal. (cc: all counsel) (gnb) [Entry date 04/16/96]

4/16/96	JUDGMENT (RSV): for defendant Moore Medical Corp., defendant Herbert Walker, defendant Group Benefit Plan against plaintiff Bonnie L. Geissal on Counts I and II of plaintiff's complaint. (cc: all counsel) (gnb) [Entry date 04/18/96] [Edit date 04/18/96]
5/3/96	NOTICE OF APPEAL filed by plaintiff Bonnie L. Geissal re: the District Court decision; [36-1] fee: $105.00 paid. (gnb) [Entry date 05/07/96]
5/3/96	RECEIPT # S96-012285 in the amount of $105.00 for Notice of Appeal/Dkt Fee, Paid for: Weinhaus & Dobson. (gnb) [Entry date 05/07/96]
5/8/96	DELIVERED TO USCA — 1 Civil Appeal Cover Sheet, 2 Certified Copies of Notice of Appeal, 2 Certified Copies of Clerk's Docket entries and 2 copies of JUDGMENT (DDN) fld. 04/16/96 and SUMMARY JUDG (DDN) fld. 03/19/96. cc: Notice of appeal to Judge Noce. cc: Notice of appeal, clerk's docket entries and USCA letter to parties. (mef)

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Docket as of February 20, 1998:

5/15/96	Civil Case Docketed. Dist. Ct. Office: St. Louis (llb)
5/15/96	CERTIFIED copies notice of appeal, docket entries [96-2285] and judgment of 4/16/96 and 3/19/96 from district court [710134] (llb)
5/15/96	BRIEFING SCHEDULE: [96-2285] Method of Apndx due on 5/28/96; DR aplnt due on 5/28/96; Aplee DR due on 6/4/96; Joint Apndx due on 6/24/96; Aplnt brief due on 6/24/96; Aplee Brief due on 7/24/96; Reply brief due on 8/7/96; (llb)
5/17/96	APPEARANCE for appellant, attorney S. Sheldon Weinhaus [96-2285] [711489] (llb)
5/24/96	DESIGNATION of record received from Appellant Bonnie L. Geisal. Type of appendix: separate [96-2285] (dmh)
6/18/96	RECORDS received: Appendix filed by Appellant Bonnie L. Geisal consisting of 1 Volume(s), 3 Copies. [96-2285] (yml)
6/18/96	BRIEF FILED - Brief of Appellant - Bonnie L. Geisal 47 pgs w/addendum - 10 copies - w/service 6/18/96. [96-2285] [723867] (skh)

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7/18/96	MOTION of Aplee, Moore Medical Corp., for extension of time to file brief until 8/21/96. [96-2285] [735853] w/service 7/17/96 (yml)
7/23/96	ORDER filed: granting in part appellee motion extension of time to file brief [735859] Aplee brief now due on 8/8/96 (yml)
8/8/96	BRIEF FILED - Brief of Appellee - Moore Medical Corp., Group Benefit Plan, Herbert Walker. 15 pgs - w/addendum - 10 copies - w/service 8/8/96. Defects Sum. of Arg. [96-2285] [743059] (yml)
8/16/96	TO SCREENING - to dcm. [96-2285] [746010] (smg)
8/19/96	RETURNED from Screening (15) [96-2285] (smg)
8/19/96	BRIEF FILED - Reply brief - Bonnie L. Geisal. 20 pgs - 10 copies - w/service 8/19/96. [96-2285] [748531] (yml)
10/9/96	*SET FOR ARGUMENT* - DECEMBER in ST. LOUIS. [96-2285] (dgh)
12/11/96	APPEARANCE for appellee, attorney Bradley J. Washburn [96-2285] [789944] (tab)

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12/11/96	ARGUED AND SUBMITTED IN ST. LOUIS TO JUDGES George G. Fagg, Circuit Judge, Floyd R. Gibson, Senior Judge, James B. Loken, Circuit Judge. S. Sheldon Weinhaus for Appellant Bonnie L. Geisal. Bradley J. Washburn for Appellees Herbert Walker, Appellees Group Benefit Plan, Appellees Group Benefit Plan Appellees Moore Medical Corp. Rebuttal by: Sheldon Weinhaus. RECORDED. [96-2285] (tab)
5/5/97	RECORDS received: Original File, consisting of 1 Volume(s), Location STL. [96-2285] (stl)
6/10/97	THE COURT: George G. Fagg, Floyd R. Gibson, James B. Loken. OPINION FILED by Floyd R. Gibson PUBLISHED. [96-2285] [862911] (mam)
6/10/97	JUDGMENT: George G. Fagg, Floyd R. Gibson, James B Loken: The judgment of the lower court is AFFIRMED in accordance with the opinion. [96-2285] [862934] (mam)
6/17/97	MOTION of aplnt, Bonnie L. Geisal, for extension of time to file petition for rehearing enbanc until 7/9/97. [96-2285] [866155] w/service 6/17/97 (mam)
6/18/97	ORDER filed: granting appellant motion extend petition for rehearing time [866155-1] [96-2285] [866157] Petition for Rehearing due on 7/9/97 (mam)

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7/9/97	PETITION for REHEARING with suggestions for rehearing en banc. Filed by Appellant Bonnie L. Geisal, w/service 7/9/97 TO COURT. [96-2285] (mjh)
7/30/97	JUDGE ORDER: denying petition for Rehearing with suggestion for rehearing en banc [875536-1] filed by Bonnie L. Geisal. Petition for panel Rehearing is also denied. [96-2285] [883216] (ema)
8/14/97	MANDATE ISSUED [96-2285] (mam)
8/20/97	RECEIPT for Mandate. [96-2285] [891667] (mam)
8/26/97	Record Sent out of the office to lower court at the end of appellate proceedings. Records Included: 1 volume OF; [96-2285] (mam)
10/28/97	U.S. Supreme Court notice regarding petition for writ of Certiorari. Filed in the Supreme Court on 97-689. Supreme Ct. Case No.: 97-689 [96-2285] [916251] (mam)
1/16/98	FEDERAL CITATION: 114 F.3d 1458 [96-2285] (sek)
2/2/98	U.S. Supreme Court order granting Supreme Court notice for certiorari. Brf of petitioner due 3/4/98; Brf of resp due 3/30/98; Reply brf due 4/14/98. [916251-1]. Order filed in the Supreme Court on 1/23/98 Sup. Ct. No. 97-689 [96-2285] (mam)

APPENDIX B — COMPLAINT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI, EASTERN DIVISION FILED JUNE 30, 1994

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94CV _____-_____

JAMES W. GEISSAL, individually and in a representative capacity on behalf of the Group Benefit Program of Moore Medical Corp.,

Plaintiff,

v.

MOORE MEDICAL CORP.,

and

GROUP BENEFIT PLAN OF MOORE MEDICAL CORP.,

and

HERBERT WALKER,

Defendants,

and

SEDGWICK NOBLE LOWNDES,

Party in Interest
and Rule 19 (a)
Defendant

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COMPLAINT

- COUNT I -
[COBRA Violations]

NOW COMES plaintiff and for his first cause of action against defendants states:

1. The Court has jurisdiction of this cause pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), as from time to time amended, 29 U.S.C. §1001 et seq.

2. MOORE MEDICAL CORP. is a corporation existing under law and engaged in commerce within the meaning of 29 U.S.C. §1002 (11) and is an industry affecting commerce within the meaning of 29 U.S.C. §1002(12), and at all times relevant hereto maintained business offices and operations within the territorial jurisdiction of this Court and this Division.

3. MOORE MEDICAL CORP. as employer established and is the plan sponsor within the meaning of 29 U.S.C. §1102 (5) and (16)(B), of defendant GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. (hereinafter "Plan"), an employee welfare benefit plan as defined in 29 U.S.C. §1002(1).

4. Defendant GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. provides for the payment and reimbursement to plan participants of various medical expenses and is a group health plan as further defined in 29 U.S.C. §1167(1).

5. Defendant MOORE MEDICAL CORP. as employer and plan sponsor is required to provide both notice and offer the

right to plan participants suffering a qualifying event as defined in 29 U.S.C. §1163, the option to continue medical coverage for certain periods of time beyond the period of the said qualifying event, all as more fully set out in the Comprehensive Omnibus Budget Reconciliation Act (COBRA), set out in relevant part at 29 U.S.C. §1161 et seq.

6. At all times relevant hereto defendant HERBERT WALKER was Vice President Human Resources for defendant and further served as both plan administrator and the named plan fiduciary as defined in 29 U.S.C. §1002(16)(A)(1) and (21); and as plan administrator and named plan fiduciary was responsible for administration of the plan and the cessation of benefits thereunder.

7. At all times relevant hereto SEDGWICK NOBLE LOWNDES served as third party administrator of plan and performed various functions of plan administrator as defined in 29 U.S.C. §1002(16)(A)(1), and at times acted for and on behalf of defendants in carrying out various administrative functions related to employer and plan interests.

8. SEDGWICK NOBLE LOWNDES is a party in interest as defined in 29 U.S.C. §1002 (14), and is a necessary party under Rule 19 (a), Federal Rules of Civil Procedure, to assure complete relief can be accorded the plaintiff.

9. At all times relevant hereto, to and including July 16, 1993, plaintiff was employed by defendant MOORE MEDICAL CORP. and a participant in defendant GROUP BENEFIT PLAN OF MOORE MEDICAL CORP., as defined in 29 U.S.C. §1002 (7).

10. Plaintiff at all times relevant hereto suffered from cancer, and he continues to suffer from such cancer and requires a great deal of continuing treatment and medical services.

11. While so employed by defendant MOORE MEDICAL CORP., plaintiff's spouse was employed by a company a stranger to the defendants and the other parties to this complaint, whereby by reason of his spouse's employment, plaintiff was also eligible as for coverage by his spouse's plan as secondary payer, and that such coverage long preceded plaintiff's termination by said defendant MOORE MEDICAL CORP.

12. At all times relevant hereto prior to plaintiff's termination of employment by defendant MOORE MEDICAL CORP. as alleged in paragraph 13 below, and for some limited time thereafter prior to the conduct of defendants alleged in paragraph 14 below, spouse's plan was secondary to coverage by defendant plan for plaintiff, and spouse's plan picked up and provided coverage when limits in GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. were exceeded.

13. On or about July 16, 1993, plaintiff suffered a termination of his employment by MOORE MEDICAL CORP., which action constituted a qualifying event as defined in 29 U.S.C. §1163, entitling him to notice and the right to exercise an option to continue group health plan coverage, as set out in 29 U.S.C. §§1166, 1161 and 1162.

14. On or about January 27, 1994 defendants unilaterally renounced any obligation to provide continuing health benefits coverage and carry out the obligations imposed upon them under the foregoing statutes and their respective obligations

under the plan, and declared any action theretofore taken by all or any one of them under 29 U.S.C. §§1161, 1163 and 1166 to be null and void and of no force, meaning or effect *ab initio.*

15. On information and belief, in so acting as described in paragraph 14 above, defendants did not determine or seek to determine whether the benefits for health care provided prior to plaintiff's termination were equal to or greater than the benefits provided if GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. coverage was to be discontinued, and the failure to provide plaintiff opportunity for COBRA continuation coverage was intentional, willful and in bad faith, with knowledge existing and/or imputed that plaintiff might be deprived needed medical treatment for an existing serious medical condition or suffer a serious diminution of assets needed for survival, and/or that plaintiff would suffer unnecessary harassment by health service providers seeking payments which plaintiff would find difficult to pay.

16. By reason of defendants' conduct amounting to in effect a refusal to provide plaintiff with information to which plaintiff as plan participant is entitled, plaintiff seeks in addition to any compensatory and equitable relief to which he may be entitled, an award in the maximum daily amount allowed by 29 U.S.C. §1132 (c).

17. The conduct alleged hereinabove of failure to provide COBRA benefits and of failure to provide proper notice, constitute a failure to administer the plan in accordance with ERISA and the terms of the plan, thereby rendering defendants liable for failure to discharge their duties with respect to the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits to participants

and beneficiaries, in accordance with 29 U.S.C. §1104, for which plaintiff seeks relief on behalf of the plan and in the interest of the plan and its participants and beneficiaries.

18. The participation in such conduct by the defendants and party in interest, warrants the removal of all plan fiduciaries and administrators, and for the Court to appoint independent fiduciaries and administrators to hereafter administer the plan, and prepare proper notices and documents, all at the cost and expense of MOORE MEDICAL CORP.

WHEREFORE, plaintiff prays for compensatory damages and for prejudgment interest on past due benefits, for such further injunctive and equitable relief as may be appropriate in the circumstances, for penalties allowable under 29 U.S.C. §1132 (c), for his costs and expenses including a reasonable attorney's fee, for punitive damages if found to be appropriate, and for such other and further relief as may be meet and just in the premises.

- COUNT II -
[Estoppel]

NOW COMES plaintiff and for his second and alternative cause of action against defendants states:

19. Plaintiff adopts, readopts and incorporates herein by reference paragraph 1 hereinabove, and further states that in the alternative this Court has jurisdiction of this second cause under the federal common law of estoppel and/or has supplemental jurisdiction under 28 U.S.C. §1367.

20. Plaintiff adopts, readopts and incorporates herein by reference paragraphs 2 through 10 and 13 and 14 above.

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21. At the time of the termination of plaintiff's employment as alleged in paragraph 13 above, defendants made representations that misled plaintiff to believe that he was entitled to COBRA continuation under law and that the terms of the GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. called for him to be offered COBRA continuation.

22. Plaintiff relied on the representations made to him as alleged in paragraph 21, to his detriment, and in reliance on such representations thereafter, among other things, continued to pay the amount required for COBRA continuation until the conduct alleged in paragraph 14 occurred, and from and after the termination alleged in paragraph 13 until the occurrence alleged in paragraph 14 occurred, defendants encouraged and continued to encourage plaintiff to make and continue such COBRA continuation premiums.

WHEREFORE, plaintiff prays for compensatory damages and for prejudgment interest on past due benefits, for such further and equitable relief as may be appropriate in the circumstances, for his costs and expenses including a reasonable attorney's fee, for punitive damages if found to be appropriate, and for such other and further relief as may be meet and just in the premises.

- COUNT III -
[Waiver]

NOW COMES plaintiff and for his third and alternative cause of action against defendants states:

23. Plaintiff adopts, readopts and incorporates herein by reference paragraph 1 hereinabove.

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24. Plaintiff adopts, readopts and incorporates herein by reference paragraphs 2 through 10 and 13 and 14 above.

25. At the time of the termination of plaintiff's employment as alleged in paragraph 13 above, defendants made representations to the effect that the plan permitted and called for plaintiff to be offered continuation beyond the termination of employment, that led plaintiff to believe that he was entitled to COBRA continuation.

26. Plaintiff relied on the representations made to him as alleged in paragraph 25, and made payments for such continuation from and after the termination alleged in paragraph 13, which continuation payments defendants accepted until the conduct alleged in paragraph 14 occurred.

27. By the conduct alleged hereinabove in paragraphs 25 and 26, defendants waived any differing construction or interpretation of plan provisions.

WHEREFORE, plaintiff prays for compensatory damages and for prejudgment interest on past due benefits, for such further and equitable relief as may be appropriate in the circumstances, for his costs and expenses including a reasonable attorney's fee, for punitive damages if found to be appropriate, and for such other and further relief as may be meet and just in the premises.

- COUNT IV -
[§104(b)(4) violation]

NOW COMES plaintiff and for his fourth and separate cause of action against defendant HERBERT WALKER as plan administrator, states:

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28. Plaintiff adopts, readopts and incorporates herein by reference paragraphs 1 through 10 and 13 and 14 above.

29. On or about May 27, 1994 plaintiff through his duly authorized agent made written demand on defendant Herbert Walker as the named plan administrator, pursuant to 29 U.S.C. §1024 (b)(4), for a complete and full copy of the entire plan documents, and advised of the obligation therefor and of the possible assessment of penalties under 29 U.S.C. §1132(c)(1) if the same not be provided within 30 days thereof.

30. The May 27, 1994 demand stated

> "In any event, as representative of Mr. Geissal and on his behalf, I hereby request of you as the named plan administrator, a copy of the health benefit plan and all relevant amendments thereto. Please understand that the law permits penalties if a copy is not sent within 30 days of this request. Those responsible may guide themselves accordingly."

31. On or about June 2, 1994 defendant sent in response only a document noted to be only a summary plan description and which document advised that it was only a summary and not the entire plan document and "does not contain all the plan details," and purported that there was a separate plan document containing "all the terms, provisions and conditions of the plan document."

32. The documentation provided on or about June 2, 1994 by defendant as purported full compliance with the May 27 request was without charge. Defendant thereby waived any right to claim charges in response to plaintiff's May 27, 1994 request.

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33. On or about June 7, 1994 plaintiff through his authorized agent, advised defendant's agent that the document production was incomplete and did not fully meet the terms of the original request.

34. The June 7, 1994 letter stated

> "Finally, and of most importance, please note that the last paragraph of my May 27 letter did not ask alone for the SPD. I asked for the plan itself and all amendments thereto. Conceivably the SPD may be the only plan document, but if that is the case I would like someone responsible to so state. The document I received at the same time I received your June 2 letter, has as a footer on each page "SPD." Ordinarily, because of various ERISA requirements, the plan and the SPD are not the same. In fact the page numbered 3 in the booklet sent, expressly notes the document is not the plan. Perhaps you intended more to be sent by your reference to have a "plan booklet" sent to me, but your client did not so understand. Please look into this. I do not want to have to sue for something which I anticipate is easy to immediately remedy."

35. On June 28, 1994 defendants acknowledged for the first time that they were aware that on June 2, 1994 they did not send all plan documentation that had been requested, offered no excuse for the attempted deception, and for other documents not clearly identified but recognized to be within the plaintiff's request, defendants demanded the payment of $50 without showing whether or how that monetary demand comported with the Secretary's regulations of reasonableness.

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36. The time allowed in 29 U.S.C. §132(c)(1) for production has now expired, and to the time of the filing of this lawsuit defendant has failed and refused to make production of any plan document other than the document purporting itself to be only a summary plan description and other than offering on June 28, 1994 other documents at a cost not clearly tied into that which the Secretary allows and contrary to the waiver alleged above.

WHEREFORE, plaintiff prays for an order compelling defendant to make production of all plan documents and if appropriate, assessment of penalties at the maximum rate allowed by statute, until such time as production is made, for such further and equitable relief as may be appropriate in the circumstances, for his costs and expenses including a reasonable attorney's fee, and for such other and further relief as may be meet and just in the premises.

WEINHAUS AND DOBSON

s/ S. Sheldon Weinhaus
By S. Sheldon Weinhaus MBE#16699
906 Olive Street, #900
St. Louis, MO 63101
314/621-8363

Attorneys for plaintiff

APPENDIX C — MOTION FOR PARTIAL SUMMARY JUDGMENT FILED JUNE 5, 1995

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DDN

JAMES W. GEISSAL, etc.

Plaintiff,

v.

MOORE MEDICAL CORP., et al

Defendants,

MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE MAIN ISSUE OF OBLIGATION OF DEFENDANTS TO PROVIDE COBRA COVERAGE

NOW COMES plaintiff and pursuant to Rule 56, FRCP, moves for entry of partial judgment in plaintiff's favor on the issue of the obligation of defendants or one of them, to provide him with a nonrevocable COBRA election and with health benefits under the health insurance plan after plaintiff timely exercised his election and paid premiums therefore.

As grounds therefore, plaintiff states

1. No contest exists to the fact that plaintiff suffered an event qualifying plaintiff for COBRA continuation coverage under 29 U.S.C. §1163, and

that plaintiff acquired no other insurance following the occurrence of such qualifying event. The interpretation of 29 U.S.C. §1162(2)(D)(i) presents no factual contest, but is a pure issue of law requiring no trial or hearing.

2. To the extent applicable, depending on the Court's view of 29 U.S.C. §1162(2)(D)(i), plaintiff presents by affidavit concurrently filed with this motion, that differences exist as between health insurance coverage provided by defendants and that provided by any preexisting coverage by reason of his spouse's employment at the time of the occurrence of the §1163 qualifying event, and that a person in plaintiff's state of health would not have reason to believe coverage only under the preexisting spousal coverage was adequate at the time of or following the §1163 qualifying event.

3. To the extent applicable, depending on the Court's view of 29 U.S.C. §1162(2)(D)(i), plaintiff presents by affidavit uncontestable fact that defendants initially offered him such continuation COBRA coverage, that he regularly and periodically as required paid premiums therefore, that he detrimentally relied on defendants' assurances of entitlement to such coverage, such that defendants are as a matter of law estopped from later revoking such coverage.

In further support hereof, plaintiff adopts, readopts and incorporates herein by reference his affidavit attached hereto, and asks the Court to further consider the pleadings and his

memorandum in support of this motion concurrently filed herewith.

WHEREFORE plaintiff moves for partial summary judgment.

APPENDIX D — AFFIDAVIT OF JAMES GEISSAL IN SUPPORT OF SUMMARY JUDGMENT

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No: 4:94 CV 1263 DDN

JAMES W. GEISSAL, etc.

Plaintiff,

v.

MOORE MEDICAL CORP., et al

Defendants,

PLAINTIFF'S AFFIDAVIT IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT ON LIABILITY ISSUES

COMES NOW plaintiff, a resident of the State of Missouri and of more than 21 years of age, and having first been duly sworn, states of his own personal knowledge as follows:

1. I am the plaintiff in the above captioned action.

2. My date of birth is May 5, 1931. I am presently 64 years old.

3. I was employed by defendant MOORE MEDICAL CORP. ("Moore") on or about July 10, 1986, when Moore acquired the business with which I had been associated.

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4. During the period of my employment by Moore, I was a participant in a health benefits plan sponsored by Moore for its employees, which included myself. That plan is the defendant GROUP BENEFIT PLAN OF MOORE MEDICAL CORP (Plan). The plan document provides during the time relevant to my lawsuit, that the corporate office then occupied by defendant HERBERT WALKER (Walker) serve as the Plan administrator. The Plan pays for various medical treatments and services for the participants.

5. During the period of my employment by Moore, I relied heavily on Plan for the payment of my medical expenses. I had and have cancer. The Plan had an annual deductible for covered medical services and treatments that I mainly needed, in the amount of $150. It also had a lifetime maximum only as to payments made by the Plan.

6. During the period of my employment by Moore, my spouse worked for Trans World Airlines (TWA), and by reason thereof, she was a covered participant and I was a covered dependent under the health insurance policy issued by Aetna Life Insurance Company (Aetna). Any payments by Aetna would be secondary to that of defendant Plan. The annual deductibles under the Aetna coverage were significantly and substantially larger than the small deductible of defendant Plan. The Aetna deductible was about $500 a year per person. Coverage of some kinds of care were different, with coverage under defendant Plan more extensive. The Aetna policy also had a lifetime maximum only as to payments made by Aetna.

7. Because of my illness, there is always the very real possibility that the expenses for my care could exceed the lifetime maximum of either the Aetna policy or the Plan separately.

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8. I was involuntarily terminated by Moore from my employment with it on July 16, 1993. I was orally told I was being terminated. A letter issued by Moore under compulsion of the Missouri Service Letter statute, uses the word "separated." A note turned over by defendants as part of their production, uses the term "laid-off." Moore's Connecticut counsel later referred to it as "termination." In any event, thereafter I no longer performed any services for Moore.

9. At the time the news media and other sources reported the continued financial distress of TWA and queried how much longer TWA might remain in business.

10. I question the reason given for my termination. In my view, the reason given in the service letter is pretextual. I did not desire to be terminated, and at the time I gave some thought to whether I should consult with an attorney to investigate and to determine what rights and claims I might have against Moore, including claims for a larger amount of termination pay, for unpaid bonus, wrongful discharge, and claims for discrimination under federal and state law. I felt Moore had been very unfair in discharging me. I knew I could complain as well to government agencies. I decided to forbear and not to pursue any of these avenues, because:

a. My main concern when I was terminated was that I have full and adequate health insurance. Although at the time I felt I had strength and fortitude, my cancer had not been cured. I anticipated much expensive medical care and treatment could possibly become necessary. Absent substantial insurance I anticipated that my and my wife's finances could even be exhausted and my wife

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left without adequate resources after my death. Should I be cured, I recognized that without adequate insurance the expenses of cure could be such that I would have no savings to draw upon. I wanted to avoid these catastrophic concerns.

b. Defendant Walker or his subordinates emphasized that I could notwithstanding the termination, still have Plan benefits available to me under COBRA. I was given an election form to continue coverage under COBRA. Walker or his subordinates stressed that I take care of the COBRA continuation option I was offered and encouraged me to make the COBRA election Moore offered to me. I was encouraged to timely make premium payments for COBRA. This conduct did much to assuage my feelings about my discharge and entitlements, sufficient that I decided to forebear taking any protective or even investigative steps beyond requesting a service letter.

c. At about the same time, and shortly after the issuance of the service letter, the Plan and/or its reinsurer were engaged in making some large medical payments for me. I found out since that time that these payments were for my prior care and not for care that I needed following my termination.

11. Apart from what actions I may have taken directly against Moore, from which I forbore, I also felt that because of the COBRA offered, I would not look for yet another insurance carrier for either primary or secondary coverage. Had I known I would be limited to only coverage through my

wife's insurer, especially considering the published threatened financial viability of that employer (TWA), I would have at the time of my termination looked for additional coverage then when I had the strength and fortitude to look and considered myself to be in much better shape than I was in at the time defendants later revoked by COBRA coverage.

12. In essence, the defendants' offer to me of COBRA continuation, and their taking of premium payments from me as described below, lulled me into several acts of forbearance.

13. As a result of documents obtained from defendants in discovery, sometime before January 20, 1994 defendants determined that they would assert I was not entitled to COBRA continuation, and started taking steps to prevent payment of benefits under my COBRA coverage. I think it may have been because of the large bills they were suddenly getting again after I had been terminated.

14. Upon my termination by Moore I received a notice of my right under COBRA to continue health insurance coverage under Plan. I exercised said continuation option, and each and every month I timely paid to defendants my monthly premium.

15. Some six months and 10 days after the termination of my employment from Moore, I was given notice by a letter dated January 27, 1994 from defendant Herbert Walker (Walker), that defendants had determined I was not entitled to COBRA coverage "since you were already covered under a group policy with Aetna," which was the health provider or third party administrator (TPA) under the TWA health benefits plan provided by TWA for its employees. I was told the months of premiums I had already paid for this continuation coverage,

would be returned and that those who had provided me with medical care during this period would not be paid by Plan and their billings would be returned to those that provided care to me. At no time earlier was I told by any of the defendants that defendants or that their own TPA were not timely paying the bills of my health care and services providers.

16. By the time of receipt of this January 27, 1994 notice from defendants, I was already far more affected by the cancer, and appreciably lacking the strength and fortitude I had when terminated. I have since learned some time limits on any claims I might have had, were only six months in length from the date of my termination, and thus had recently expired. I certainly did not have any six months to start an investigation or take action. I was foreclosed.

17. Sometime after this January 27, 1994 notice I retained Sheldon Weinhaus to represent me on the claims asserted in this lawsuit. He had and was given my full authority to ask for documents and information relating to the Plan.

Further affiant saith not.

s/ James W. Geissal
JAMES W. GEISSAL

APPENDIX E — SUBSTITUTION OF PARTY PLAINTIFF FILED NOVEMBER 1, 1995

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DNN

JAMES W. GEISSAL, etc.

Plaintiff,

v.

MOORE MEDICAL CORP., et al

Defendants,

SUBSTITUTION OF PARTY PLAINTIFF

Upon the suggestion of the death of the plaintiff JAMES W. GEISSAL, and the Court being advised that Letters Testamentary have been issued to BONNIE L. GEISSEL by the Probate Division of the Circuit Court of the County of St. Louis, Missouri, in the Estate of James W. Geissal, estate 120010, on oral application of said Personal Representative the Court hereby substitutes BONNIE L. GEISSEL as Personal Representative of the Estate of James W. Geissal, deceased. The Clerk shall change the caption of the cause accordingly to reflect such substitution.

WEINHAUS AND DOBSON

s/ S. Sheldon Weinhaus MBE #16699
906 Olive Street, #900
St Louis, Mo 63101
314/621-8363
Attorneys for plaintiff

SO ORDERED

s/ David D. Noce
U.S. Mag. Judge
Date: 11-1-95

APPENDIX F — ORDER AND MEMORANDUM OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI, EASTERN DIVISION FILED MARCH 19, 1996

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

BONNIE E. GEISSAL,[1]

Plaintiff,

v.

MOORE MEDICAL CORP., et al.,

Defendants.

No. 4:94 CV 1263 DDN

ORDER

In accordance with the Memorandum filed herewith,

IT IS HEREBY ORDERED that plaintiff's motion for partial summary judgment (Doe. No. 20) is denied.

IT IS FURTHER ORDERED that summary judgment is entered for the defendants and against the plaintiff on Counts I and II of the amended complaint. Counts I and II are dismissed.

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1. Upon the death of plaintiff James W. Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted as party plaintiff Fed. R. Civ. 25(a).

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IT IS FURTHER ORDERED that the parties shall have forty-five days in which to file motions for summary judgment on Counts III and IV.

s/ David D. Noce
UNITED STATES MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

Appendix F

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

BONNIE L GEISSAL,[1]

Plaintiff,

v.

MOORE MEDICAL CORP., et al.,

Defendants.

No. 4:94 CV 1263 DDN

MEMORANDUM

This matter is before the Court upon the plaintiff's motion for partial summary judgment (Doe. No. 20) The parties have consented to the jurisdiction to the United States Magistrate Judge pursuant to 28 U.S.C. § 636(c).

This case involves the continuation coverage provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. § 1001 *et seq*. Plaintiff is Bonnie L. Geissal, wife and personal

1. Upon the death of plaintiff James W Geissal, Bonnie L. Geissal, personal representative of the estate of James W. Geissal, was substituted on November l, 1995, as party plaintiff. Fed. R. Civ. P. 25(a). References to plaintiff in the masculine in this Memorandum are to decedent.

representative of the estate of James W. Geissal, who is now deceased. Defendants are Moore Medical Corporation, Group Benefit Plan of Moore Medical Group and Herbert Walker. On plaintiff's motion, Sedgwick Nobel Lowndes, originally named as a defendant, was dismissed without prejudice by order of the Court on November 8, 1994.

Count I alleges that defendants violated COBRA by failing to provide continuation insurance coverage once Moore terminated Geissal's employment. Count II alleges that defendants are estopped from denying coverage because at the time of Geissal's termination, defendants made misrepresentations that made him believe that he was entitled to COBRA continuation and would have insurance coverage. Plaintiff alleges that Geissal relied on these representations and continued to pay the amount required for COBRA continuation. Count III alleges waiver, in that, by accepting Geissal's payments, defendants waived any differing construction or interpretation of ERISA plan documents. Count IV, which is not the subject of the pending motion, alleges that Herbert Walker, as plan administrator, failed to provide requested plan documents as required by statute.

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage.

The following facts are without dispute:

FACTS

1. On July 16, 1993, Moore Medical Corp. (Moore or Moore Medical) terminated James Geissal. (Geissal Affidavit, filed June 5, 1995, at ¶ 8; Defendants' Answer, filed July 28, 1994.) At

the time of his termination, Geissal was 62 years old and had cancer. (Geissal Aff. at ¶¶ 2, 5.) During his employment at Moore, Geissal was a participant in a health benefits plan, the Group Benefit Plan of Moore Medical Corp., sponsored by Moore for its employees. (Geissal Aff. at ¶ 4; Complaint at ¶ 9; Answer at ¶ 9.)

2. Moore Medical Corp. is an employer and the plan sponsor, within the meaning of 29 U.S.C. § 1102(5) and (16)(B), of defendant Group Benefit Plan (Plan) of Moore Medical Corp. The plan is an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1). Defendant Group Benefit Plan of Moore Medical Corp. provides for the payment and reimbursement to plan participants of various medical expenses and is a group health plan as defined in U.S.C. § 1167(1). (Complaint at ¶¶ 3, 4; Answer at ¶¶ 3, 4.)

3. While Geissal was employed at Moore, his wife, Bonnie, was employed by Trans World Airlines (TWA). (Complaint at ¶ 11; Answer at ¶ 11; Geissal Aff at ¶ 6.) By reason of Bonnie Geissal's employment at TWA, James Giessal was a covered dependent eligible for coverage under the health insurance policy issued by Aetna Life Insurance Company, which was the health provider or third-party administrator under the TWA plan provided by TWA for its employees. (Geissal Aff. at ¶ 6, 15.) Geissal's coverage through his wife's plan preceded Geissal's termination by Moore. (Complaint at ¶ 11.)

4. Upon Geissal's termination at Moore Medical, Geissal received a notice of his right under COBRA to continue health insurance coverage under Moore's benefit plan. He accepted Moore's offer and elected to continue receiving group health coverage under Moore's Plan. He began making premium

payments. (Geissal Aff. at ¶ 14.) The defendant accepted the payments. Approximately six months after his termination, by letter dated January 27, 1994, defendants informed Geissal that they had determined he was not entitled to COBRA coverage because he was already covered under a group policy with Aetna. (Geissal Aff. at ¶ 15.) Geissal was told that the premiums he had already paid would be returned and that those who provided him with medical care during that period would not be paid by the Plan and their billings would be returned to those who had provided medical care to him. (Geissal Aff. at ¶ 15.)

5. Moore's plan had an annual deductible of $150. It also provided for a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 5.) TWA's plan through Aetna had an annual deductible of $500 per year per person and also provided a lifetime maximum amount of benefits. (Geissal Aff. at ¶ 6.)

6. At the time Geissal was terminated, he requested and received a service letter pursuant to Missouri Rev. Stat. § 290.140. (Geissal Aff. at ¶¶ 8, 10b.) At the time he was terminated, he considered whether he should consult an attorney to investigate what rights and claims he might have against Moore because he felt he was unfairly terminated. (Geissal Aff. at ¶ 10.) Geissal decided not to do so, because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶ 10a.) Moore representatives encouraged him to make the COBRA election, which did much to assuage his feelings about his discharge. (Geissal Aff. at ¶ 10 b.) At about this time, and shortly after the issuance of the service letter, the Plan or its reinsurer were making large payments for medical care provided to Geissal prior to his termination. (Geissal Aff. at ¶ 10c.) Because he was offered the COBRA continuation coverage, Geissal did not look for another insurance carrier. (Geissal Aff. at ¶ 11.)

DISCUSSION

Plaintiff has moved for partial summary judgment on the issue of defendants' obligation to provide COBRA coverage. Plaintiff states that Counts I, II and III are related to that issue. However, plaintiff has not argued the issue of waiver, which is the basis for Count III. Plaintiff states that a finding of liability on Count I would moot Counts II and III

This Court must grant summary judgment if, based upon the pleadings, admissions, depositions and affidavits, there exists no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corporation v. Catrett*, 477 U.S. 317, 322 (1986); *Board of Education, Island Trees Union Free School Dist. v. Pico*, 457 U.S. 853, 863 (1982). The moving party must initially demonstrate the absence of an issue for trial. *Celotex Corporation*, 477 U.S. at 323. Any doubt as to the existence of a material fact must be resolved in favor of the party opposing the motion *Board of Education v. Pico*, 457 U.S. at 863.

Nevertheless, once a motion is properly made and supported, the non-moving party may not rest upon the allegations in his pleadings but must instead set forth specific facts showing that there is a genuine issue of material fact for trial. Fed. R Civ. P. 56(e); *Buford v. Tremayne*, 747 F.2d 445, 447 (8th Cir. 1984). Summary judgment must be granted to the movant if, after adequate time for discovery, the non-moving party fails to produce any proof to establish an element essential to the party's case and upon which the party will bear the burden of proof at trial. *Celotex Corporation*, 477 U.S. at 322-24.

In response to the motion, defendants have raised several issues. First, defendants argue that the plaintiff lacks standing

to maintain the instant lawsuit because plaintiff has no economic damages. Based upon the discovery supplied by plaintiff and Aetna, which was the group insurance carrier under the spouse's preexisting health benefit plan, defendants assert that all of plaintiff's medical bills for "covered expenses" during the relevant period were paid by Aetna. Therefore, defendants claim, plaintiff has no claim for compensatory damages or other type of damages because he has suffered no damages. The Court nevertheless concludes that plaintiff has standing to bring this lawsuit for relief other than compensatory damages. *See* 29 U.S.C. § 1132(a) (1).

Second, defendants argue that a necessary party needed for complete adjudication pursuant to Federal Rule of Civil Procedure 19(a) is not before the Court. Defendants argue that the real party in interest is Aetna, the health provider for the TWA plan, and TWA, Bonnie Geissal's employer. Defendants argue that the question is whether Moore or Aetna should pay for the covered medical expenses during the COBRA-continuation period. Defendants argue that if the Court were to hold that Moore should have provided COBRA coverage to Geissal and that such policy was primary to Aetna's policy, then Aetna should be reimbursed by Moore for all "covered expenses" incurred by Geissal during the COBRA period. Further, the plaintiff would owe the Moore health plan $2,673.18 for 18 months of COBRA coverage. They argue that there is a possibility of a double recovery for plaintiff.

Plaintiff, in response, argues that defendants have waived the defense of failure to join a necessary party. However, because this defense can be raised as an issue at a trial on the merits, *see* Federal Rule of Civil Procedure 12(h)(2), the question of whether there is a genuine issue for trial with regard to this

defense can appropriately be raised on a motion for summary judgment. *See Kornblum v. St. Louis County*, 48 F.3d 1031, 1038 (8th Cir.), *opinion vacated on other grounds*, 72 F.3d 661 (8th Cir. 1995).

The question of whether a party must be joined is examined under Federal Rule of Civil Procedure 19 (a), which states in pertinent part:

> A person who is subject to service of process and whose joinder will not deprive the court of jurisdiction over the subject matter of the action shall be joined as a party in the action if (1) in the person's absence complete relief cannot be accorded among those already parties, or (2) the person claims an interest relating to the subject of the action and is so situated that the disposition of the action in the persons absence may (i) as a practical matter impair or impede the person's ability to protect that interest or (ii) leave any of the persons already parties subject to a substantial risk on incurring double, multiple, or otherwise inconsistent obligations by reason of the claimed interest.

Aetna is not a necessary party under the first subsection of Rule 19 (a), because complete relief may be granted between Moore and plaintiff without Aetna's joinder. Moore may be required to continue coverage, in consideration for premiums paid. Because Aetna has already paid claims, its joinder is not necessary in order for plaintiff to obtain relief from Moore.

Therefore, defendants must rely on Rule 19 (a)(2), which requires a finding that Aetna "claims an interest relating to the

subject matter of the action." Assuming that Aetna "claims" such an interest, the remaining requirements of Rule 19(a)(2) are not met. Aetna's absence from this case will not impair or impede its ability to protect that interest. If the Court decides that Moore should have provided COBRA coverage, Aetna could decide what future recourse, if any, to take. The possibility of potential litigation is irrelevant to the criteria of Rule 19. "The focus is on relief between the parties and not on the speculative possibility of further litigation between a party and an absent person." *LLC Corp. v. Pension Benefit Guaranty Corp.*, 703 F.2d 301, 305 (8th Cir. 1983). In addition, a determination of the case in the absence of Aetna will not subject Moore to the risk of inconsistent or double obligations.

Third, defendants argue that the Court cannot grant relief against them unless it finds that the Moore health plan was primary to the Aetna health plan. This determination can be made upon adequate discovery, without Aetna's presence as a party.

The cardinal issue between the present parties is whether James Geissal's preexisting (Aetna) insurance coverage made him ineligible for continuation coverage with the Fund upon his termination. The resolution of that issue is one of statutory interpretation. ERISA, as amended by the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. § 1161-1168, requires employers to offer continuation coverage to certain categories of departing employees. COBRA specifies the circumstances which entitle an employer to terminate continuation coverage. The termination provision at issue in this case is as follows:

> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

* * *

> (D) The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) covered under any other group health plan (as an employee or otherwise) 'which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.'

29 U.S.C. § 1162(2)(D)(i).

Plaintiff argues that the plain language of the statute mandates that only other group coverage which is obtained *after* the date of the election can preclude COBRA entitlement and selection. Therefore, because Geissal's coverage under his wife's plan existed *before* he elected the COBRA continuation plan, plaintiff argues that James Geissal is entitled to continuation coverage under the Moore Plan.

In interpreting a statute, a Court is required to look to the plain language of the statute, give significance to the statute as a whole, and to examine the purpose and intent of a statute when deciding what its terms mean. *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *Richards v. United States*, 369 U.S. 1, 11 (1962); *National Labor Relations Board v. Lion Oil Co.*, 352 U.S. 282, 289-90 (1957); *United States Department of Health and Human Services v. Smith*, 807 F.2d 122, 126-27 (8th Cir. 1986).

Five Circuit Courts of Appeals have considered whether COBRA authorizes an employer to withhold continuation coverage when the departing employee has dual coverage

throughout his employment and therefore has a continuing source of coverage when he resigns or is terminated. *See Lutheran Hospital of Indiana, Inc. v. Business Men's Assurance Co. of America*, 51 F.3d 1308 (7th Cir. 1995); *McGee v. Funderberg*, 17 F.3d 1122 (8th Cir. 1994); *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir 1990); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990).

The Tenth Circuit was the first circuit to address the issue in *Oakley*.[2] At the time of plaintiffs termination, he had insurance under his employer and was also a dependent under his wife's group health plan. However, his wife's plan, unlike his employer's plan, did not cover the costs of the medical treatment he needed. The court found that the plain meaning of the statute "cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage." *Oakley*, 890 F.2d at 1132. The court read the language of subsection (i) to refer to other coverage occurring *after* the qualifying event. *Id.* (emphasis added).

In *Brock*, the plaintiff elected continuation coverage when she was terminated. Both before and alter her termination, she also was covered as a dependent on her husband's group health insurance plan. The Fifth Circuit held that plaintiff was not entitled to continuation coverage under COBR[illegible]. *Brock*, 904 F.2d at 297.

In *National Companies*, the plaintiff elected, upon his resignation, to continue receiving group health coverage under

2. The actual provision at issue in *Oakley* was 42 U.S.C. § 300bb-2(2)(D)(I), which covers public employees. However, it is identical to the provision at issue in this case.

his employer's plan. Both before and after his resignation, he was also covered under the group health plan of his wife's employer. Plaintiff had paid premiums and the premiums were accepted. The Eleventh Circuit held that an ERISA provider is not required to offer continuation coverage to an employee or his dependents who are covered under a preexisting group health plan. *National Companies*, 929 F.2d at 1566. The court held that

> it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date. In effect, such an employee is ineligible for continuation coverage.

Id. at 1570.

In *McGee*, the plaintiff's deceased husband had health insurance as a benefit of his membership in a union. Upon his retirement, he elected continuation health coverage under COBRA and paid his monthly premiums. When he was diagnosed with cancer and began submitting claims for payment of medical expenses, the Fund terminated COBRA coverage on the basis that he was covered by another group health care plan. *McGee*, 17 F.3d at 1123. The district court adopted the rationale of the Eleventh Circuit in *National Companies*. On appeal, the Eighth Circuit found the Eleventh Circuit's reasoning "attractive," but concluded that it need not decide the question

of whether preexisting coverage defeated the employee's eligibility for continuation coverage. *Id.* at 1124.

In *Lutheran*, plaintiff was covered under both her employer's and her husband's group health plans. Plaintiff had a neurological disorder. She was then laid off. Her employer's insurance company told her she would not be eligible for COBRA coverage because of her preexisting coverage under her husband's plan. *Lutheran*, 51 F.3d at 1310 & n.1. The court held that the clear language of the statute provides that an employee loses the right to continuation coverage only if he chooses after the election date to accept coverage under another group health plan. *Id.* at 1312. Therefore, preexisting coverage would not make an employee ineligible for COBRA coverage. "The statutory distinction between preexisting and after-acquired health care coverage is reasonable and facilitates the preservation of the beneficiary's health care status quo." *Id.*

The undersigned finds the reasoning of the Eleventh Circuit persuasive and therefore holds that James Geissal's preexisting coverage under his wife's plan constitutes coverage "under any other group health plan" for purposes of 29 U.S.C. § 1162(2)(D)(i).

The fact that Geissal had other coverage is not entirely dispositive, however. According to the plain language of the statute, if the other coverage contains an "exclusion or limitation with respect to any preexisting condition of [the] beneficiary," the employee may be eligible for continuation coverage.

The question is whether there was a gap between the coverage offered by the employer and that offered by the other insurance. Circuit Courts of Appeal have examined the relative coverage available to the beneficiary under both plans.

In *Oakley*, the plaintiff sought coverage for rehabilitation therapy for a brain injury. This treatment was covered under the plan provided by his former employer but was not covered under his spouse's plan. *Oakley*, 890 F.2d at 1130. The court held that plaintiff's coverage under his spouse's plan did not render him ineligible for continuation coverage from his former employer. In dicta, the Tenth Circuit noted that there was a gap between plaintiff's coverage under his employer's plan and his coverage under his wife's plan. *Id.* at 1133. The court noted that "the facts of this case illustrate the precise gap in coverage which troubled Congress;" in other words, forcing the plaintiff's family to pay for the treatment of his catastrophic injury would put plaintiff and his family at risk and jeopardized his treatment. *Id.* at 1133.

In *Brock*, the Fifth Circuit held that preexisting coverage rendered a departing employee ineligible for continuation coverage. However, the court also noted that there was no "gap" in plaintiff's coverage under the two plans. Specifically, the court noted that plaintiff was covered under both plans for the type of medical problem for which she later claimed benefits. *Brock*, 904 F.2d at 297.

The Eleventh Circuit showed a similar concern in *National Companies* when it examined the character of plaintiff's coverage under his former employer's plan and under his spouse's preexisting plan. *National*, 929 F.2d at 1571. While the court held that an employer was not required to provide continuation coverage to an employee who was covered under a preexisting group health plan, it also held that an employee may be entitled to receive continuation coverage under his previous employer's plan, if there is a significant gap between the employer's plan and the preexisting plan. *Id.* at 1571. If

there is a significant gap in coverage such that the employee would become personally liable for substantial medical expenses to his family's detriment, the employee would not truly be "covered" under the preexisting plan. *Id.* The court noted that Congress' purpose in enacting COBRA was to respond to "the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." *National*, 929 F.2d at 1567 (quoting H.R. Rep. No. 241, 99th Cong., 2d Sess. 44, *reprinted in* 1986 U.S.C.C.A.N. 579, 622). The court concluded that denial of continuation coverage when the employee's only other coverage does not truly cover the employee would frustrate Congress' intentions. *Id.*

In *McGee*, the Eighth Circuit noted in dicta that a significant gap between coverage afforded under the employer's plan and that afforded under the preexisting plan would entitle plaintiff to COBRA coverage. *McGee*, 17 F.3d at 1126. The court quoted *National* for the proposition that when a gap in coverage exists, then the employee is not truly covered by the preexisting group health plan. *Id.* The court found that there was a significant gap because plaintiff remained personally liable for more than $7,500 under the preexisting plan, while under her employer's plan she would have been personally liable for only $1,000 in medical expenses. *Id.*

In this case, plaintiff maintains that there is a significant gap between the coverage provided by Moore and that provided by the preexisting plan because (1) Moore's plan had an annual deductible of $150 for covered medical services and treatments that Geissal needed, while Aetna's plan had an annual deductible of $500 per year per person; (2) Moore's plan had a lifetime maximum only as to payments made by the Plan and Aetna's

plan had a lifetime maximum as to payments made by Aetna; therefore, before his termination Geissal had the benefit of two maximums; (3) coverage of some kinds of care were different, with coverage under Moore's plan being more extensive. (Affidavit of James Geissal, filed June 5, 1995, at ¶¶ 5-7.)

Plaintiff does not allege that James Geissal suffered from a preexisting condition that was not covered under Aetna's plan. Plaintiff does not allege that Geissal's condition was not covered by Aetna. Although the record is unclear about the exact amount of benefits paid or the extent of coverage, there is no dispute that benefits were in fact paid. The only difference between the two policies that Geissal asserted in his affidavit is the amount of deductible. This is not a significant gap. *See National*, 929 F.2d at 1571. A significant gap in coverage exists when coverage is excluded or limited for certain types of conditions or treatments. *See, e.g., Brock v. Primedica, Inc.*, 904 F.2d 295, 297 (5th Cir. 1990). Plaintiff has provided no evidence that coverage under the TWA plan was excluded or limited for Geissal's condition.

Plaintiff argues that, even if Moore was not required to provide continuation coverage to James Geissal, it is estopped from denying such coverage. *See National*, 929 F.2d at 1571-74. Plaintiff alleges a federal common law claim of estoppel in Count II.[3]

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3. The Eighth Circuit has not recognized a federal common law action for equitable estoppel, although it has been suggested that it would do so in certain circumstances. *Slice v. Sons of Norway*, 34 F.3d 630, 633-34 (8th Cir. 1994); *Coonce v. Aetna Life Insurance Co.*, 777 F. Supp. 759, 769-70 (W. D. Mo. 1991). *See also McGee*, 17 F.3d at 1126.

The elements of equitable estoppel, as defined by federal common law, are that (1) the party to be estopped misrepresented material facts; (2) the party to be estopped was aware of the true facts; (3) the party to be estopped intended that the misrepresentation be acted on or had reason to believe the party asserting the estoppel would rely on it; (4) the party asserting estoppel did not know, nor should it have known, the true facts; and (5) the party asserting the estoppel reasonably and detrimentally relied on the misrepresentation. *Heckler v. Community Health Services, Inc.*, 467 U.S. 51, 59 (1984); *National*, 929 F 2d at 1572; *United States v Aetna Casualty & Surety Co.*, 480 F.2d 1095, 1099 (8th Cir. 1973).

Plaintiff argues that Geissal was offered continuation coverage, (Aff. at ¶¶ 10b, 12) and that he relied upon that offer to his detriment. (Aff. at 10, 11). He stated that he did not look for other insurance, knowing how weak TWA was financially and how he needed more than what TWA provided, and he did not pursue investigation as to defendants' possible misconduct in terminating him.

In *National*, the court found that the employer had misrepresented to plaintiff that he was entitled to and would receive continuation coverage, in a memorandum explaining continuation coverage; that by accepting premium payments for four months, the company continually assured plaintiff that the Plan was providing him with coverage; that Plan representatives knew or believed, prior to plaintiff's resignation, that plaintiff was ineligible for continuation coverage because of his preexisting coverage; that plaintiff relied on the company's memorandum notifying him of his rights with respect to continuation coverage; that plaintiff was unaware of the true facts because there was no evidence that plaintiff knew he was

not entitled to continuation coverage; and that plaintiff relied on those representations by deciding not to accept coverage under another policy when he learned he would be entitled to continuation coverage. In addition, plaintiff incurred personal liability for $6,700 in medical expenses he would not have incurred had he maintained dual coverage. *National*, 929 F.2d at 1573-74.

In *McGee*, McGee elected, upon retirement, to continue coverage and he paid monthly premiums. When he was diagnosed with cancer and began to submit claims for payment of medical expenses, his employer's plan terminated COBRA coverage. *Id.* at 1123. McGee continued to tender premium payments until he died, but the Fund refused to accept the payments. *Id.* The Eighth Circuit indicated in dicta that the doctrine of equitable estoppel might be applicable to such a case, in which the employers plan accepted the employee's premiums for months, denied coverage when he became sick, and he relied to his detriment on the Fund's representations that COBRA coverage would be afforded. *McGee*, 17 F.3d at 1126.

In this case, there is no dispute that defendants told Geissal he was entitled to continuation coverage. In addition, defendants accepted Geissal's premium payments for about six months, from the date of termination, July 16, 1993, until he was notified on January 27, 1994, that Moore had determined he was not entitled to COBRA coverage. There is no evidence that Plan Representatives previously knew he was covered by a preexisting policy. However, the Court will assume that the defendants had constructive knowledge because of their obligation to know every ERISA provision and to determine employees' rights. *National*, 929 F.2d at 1573 n.15. There is no dispute that Geissal

relied on the company's notification that he was entitled to continuation coverage. There also is no dispute that Geissal was unaware of the true facts, *e.g.*:, that the preexisting policy disqualified him from COBRA coverage.

However, while plaintiff asserts that Geissal relied on those representations, there is no evidence that he relied on them to his detriment. Plaintiff has not shown that Geissal suffered any economic loss. *See National*, 929 F.2d at 1574 n.16. Geissal stated that, although he gave some thought to whether he should consult an attorney to investigate what rights and claims he may have had against Moore concerning his termination and he knew that he could complain to government agencies about his termination, he decided not to do so because his main concern was that he have full and adequate health insurance. (Geissal Aff. at ¶¶ 10 and 10a.) He further stated that Moore representatives encouraged him to make the COBRA election offered by Moore, and that conduct did much to assuage his feelings about his discharge, so much so that he decided against taking any investigative steps beyond requesting a service letter. (Geissal Aff. at ¶ 10b.) Geissal stated that he later learned that, by the time Moore informed him that he was not entitled to COBRA coverage, his termination-related claims were time-barred. (Geissal Aff. at ¶ 16.)

Geissal's statements are insufficient to show detrimental reliance. There is no evidence that Geissal accepted the COBRA coverage as part of an express agreement not to take legal action against Moore concerning his termination. Geissal's statements of inchoate claims are speculative and insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e).

Geissal also states that, had he known he would be limited to coverage only through his wife's policy, he would have

looked for additional coverage. (Geissal Aff. at ¶ 11.) This statement is speculative at best concerning the outcome of any such search for other coverage, and the statement is insufficient to withstand summary judgment. *Smith v. Hartford Insurance Group*, 6 F.3d 131, 137 (3d Cir. 1993); Fed. R. Civ. P. 56(e). This is not a case where Geissal found other insurance coverage but decided not to purchase it because of Moore's representation about COBRA continuation coverage. *See National*, 929 F.2d at 1574.

For these reasons, the plaintiff's motion for partial summary judgment will be denied. The material facts are undisputed and defendants are entitled to judgment on Counts I and II as a matter of law. Therefore, judgment will be entered in favor of the defendants on Counts I and II. *Madewell v. Downs*, 68 F.3d 1030, 1048-50 (8th Cir. 1995).

Count III alleges that the defendants, by accepting Geissal's payments, waived any differing construction or interpretation of plan documents. Plaintiff did not move for summary judgment on that ground and the parties have not argued it. The doctrines of waiver and estoppel are distinct. *Karlen v. Ray E. Friedman & Co. Commodities*, 688 F.2d 1193, 1197 (8th Cir. 1982). *See Buder v. Fiske*, 174 F.2d 260, 267-68, *reh'g denied*, 177 F.2d 907 (8th Cir. 1949). Plaintiff also did not seek summary judgment on Count IV.

An appropriate order is issued herewith.

s/ David D. Noce
UNITED STATES MAGISTRATE JUDGE

Signed this 19th day of March, 1996.

APPENDIX G — ORDER FOR ENTRY OF FINAL JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI, EASTERN DIVISION FILED APRIL 4, 1996

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:94 CV 1263 DDN

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased, etc.

Plaintiff,

v.

MOORE MEDICAL CORP., et al

Defendants,

ORDER FOR ENTRY OF FINAL JUDGMENT COUNTS I AND II

On application of plaintiff and without objection of defendants, the Court hereby determines and finds that by reason of the rationale expressed in the Court's memorandum of March 19, 1996 entered in this matter, entering summary judgment in favor of defendants on the Court's own motion on Counts I and II, the Court hereby expressly determines there is no just reason for delay of entry of final judgment in favor of defendants on Counts I and II. The Court hereby directs the

Appendix G

Clerk to enter final judgment in favor of defendants on Counts I and II. In the event plaintiff timely appeals from the entry of such judgments, further action on Counts III and IV shall be stayed until disposition of the appeal.

s/ David D. Noce
United States Magistrate Judge

Dated at St. Louis MO
April 4, 1996

APPENDIX H — ENTRY OF JUDGMENT BY THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI FILED APRIL 16, 1996

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI

JUDGMENT IN A CIVIL CASE

CASE NUMBER: 4:94 CV 1263 DDN

BONNIE L. GEISSAL as representative of the Estate of JAMES

Plaintiff(s),

v.

MOORE MEDICAL CORP., et al.

Defendant(s)

* * *

☒ **Decision by Court.** This action came before the Court on motion for summary judgment and entry of final judgment. Motions having been decided, and at the direction of the Court, judgment is entered accordingly;

IT IS HEREBY ORDERED AND ADJUDGED that final judgment is entered in favor of defendants Moore Medical Corporation, Herbert Walker and Group Benefit Plan, and against plaintiff Bonnie Geissal on Counts I and II of plaintiff's complaint.

Appendix H

Robert D. St. Vrain
CLERK

By: s/ Gilbert N. Beckemeier, III

Gilbert N. Beckemeier, III
Deputy Clerk

April 16, 1996
DATE

APPENDIX I — RELEVANT ACTS

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986, Pub. L. No. 99-272, Sec. 10002, 100 Stat. 228, April 7, 1986 (codified as amended at 29 U.S.C. § 1162 (2) (D) (i) (1997)).

SEC. 602 CONTINUATION COVERAGE.

For purposes of section 601, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

(1) TYPE OF BENEFIT COVERAGE. * * *

(2) PERIOD OF COVERAGE. The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) MAXIMUM PERIOD. * * *

(B) END OF PLAN. * * *

(C) FAILURE TO PAY PREMIUM. * * *

(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.

The date on which the qualified beneficiary first becomes, after the date of the election —

(i) a covered employee under any other group health plan, or

Appendix 1

TAX REFORM ACT OF 1986, Pub. L. No. 99-514, Sec. 1895, 100 Stat. 2938, October 22, 1986 (codified as amended at 29 U.S.C. § 1162 (2) (D) (i) (1997)).

SEC. 602 CONTINUATION COVERAGE.

* * *

(2) PERIOD OF COVERAGE. * * *

(D) GROUP HEALTH PLAN COVERAGE OR MEDICARE ELIGIBILITY. The date on which the qualified beneficiary first becomes, after the date of the election —

(i) covered under any other group health plan

(as an employee or otherwise), or

Appendix 1

CONSOLIDATED BUDGET RECONCILIATION ACT OF 1986, Pub. L. No. 101-239, Sec. 7862, 103 Stat. 2432, Dec. 19, 1989 (codified as amended at 29 U.S.C. § 1162 (2) (D) (i) (1997)).

SEC. 602 CONTINUATION COVERAGE.

* * *

(2) PERIOD OF COVERAGE. * * *

(D) GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMENT. The date on which the qualified beneficiary first becomes, after the date of the election —

(i) covered under any other group health plan, (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or

Appendix 1

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, Pub. L. 104191, Sec. 421, 110 Stat. 2088, Aug. 21, 1996 (codified as amended at 29 U.S.C. 1162 (2) (D) (i) 1997))

§ 1162 CONTINUATION COVERAGE.

* * *

(2) PERIOD OF COVERAGE. * * *

(D) GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMENT. The date on which the qualified beneficiary first becomes, after the date of the election —

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 19867 part 7 of this subtitle, or title XXVII of the Public Health Service Act), or

No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR PETITIONER

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QUESTIONS PRESENTED FOR REVIEW

I. Does pre-existing spousal/dependent health insurance coverage require the termination of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act [COBRA] for an otherwise qualified beneficiary?

II. If Congress intended that coverage may be continued where there is a "significant gap" in coverage between the two policies, should the courts decide whether a "significant gap" exists? If so, how?

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OPINIONS AND JUDGMENTS BELOW

The district court found against Petitioner and in favor of Respondents on Count's I and II of her complaint, *Bonnie Geissal v. Moore Medical Corp., et al.*, No. 4:94CV1263DDN (March 19, 1996), denying plaintiff's/appellant's motion for summary judgment and finding on the Court's own motion summary judgment in favor of Respondents, which is published at 927 F. Supp. 352, and is reprinted at 35a-55a. Judgment was entered by the Honorable David D. Noce, United States Magistrate Judge, Eastern District of Missouri. The Eighth Circuit Court of Appeals' affirmance of the decision of the district court is found at 114 F.3d 1458 (8th Cir. 1997).

STATEMENT OF SUPREME COURT JURISDICTION

The district court had jurisdiction of this action pursuant to 28 U.S.C. § 1331, and under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and particularly 29 U.S.C. §§ 1132(a) and 1161. During the course of the proceedings in the district court, the original plaintiff died and the personal representative of his estate was substituted as party plaintiff. She is the petitioner herein.[1] Final judgments were entered on April 16, 1996 pursuant to Rule 54(b), Federal Rules of Civil Procedure by the Magistrate Judge acting under consent given pursuant to 28 U.S.C. § 636(c)(1). Petitioner filed timely notice of her appeal pursuant to 28 U.S.C. § 1291 on May 3, 1996. Fed. R. App. P. 4(a). The Eighth Circuit affirmed on June 10, 1997, and Petitioner's motions for rehearing were denied on July 30, 1997. Petitioner filed a timely Petition for Writ of Certiorari, pursuant to Supreme Court Rule 13.1 on October

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1. Petitioner Bonnie L. Geissal maintains this action "as beneficiary and representative of the Estate of James W. Geissal, deceased, individually, and in a representative capacity on behalf of the Group Benefit Program of Moore Medical Corp." The Respondents are: "Moore Medical Corporation; Group Benefit Plan of Moore Medical Corp.; [and] Herbert Walker."

20, 1997, which was within 90 days of the denial of rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254.

PERTINENT STATUTES

The text of the relevant statutes in this case is set forth in an appendix to the brief.

STATEMENT OF THE CASE

The essential question in this case is the right of plaintiff to continue his health insurance coverage under the provisions of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA"), incorporated as an amendment into the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1161, *et seq.*

A. Facts

James W. Geissal, the original plaintiff in this action, while employed by defendant/appellee Moore Medical Corporation, was entitled to health care benefits from a group plan established by the employer. Mr. Geissal's wife Bonnie worked for Trans World Airlines which provided for its employees and their spouses health care benefits through its Aetna Life Insurance Company group health plan. Dual coverage thus existed during Mr. Geissal's employment.

Mr. Geissal suffered from solid tumor cancer, a condition that usually means metastases and an eventual and painful death after long and expensive treatment and care that could easily consume one's life savings. Mr. Geissal's employer learned about the cancer. Mr. Geissal was terminated. At the time of termination defendants assured Mr. Geissal of eligibility for COBRA continuation, and encouraged him to so elect to continue his coverage and pay premiums, which he did. As a result, he did not seek to replace the coverage by defendants when he was first terminated, believing

the dual coverage he was assured he would have by paying COBRA premiums, was still sufficient. Only after requests came in for payment for the mounting expenses of cancer treatment did defendants advise Mr. Geissal that he was not entitled to and ineligible for COBRA coverage. The reason given was that Mr. Geissal remained eligible to receive health benefits under his wife's group policy. They proposed to pay back his premiums. This suit ensued.

B. Court History

The suit brought by plaintiff/appellant contained four counts: the first alleged a straightforward COBRA violation; Count II alleged liability to continue COBRA health insurance on an estoppel theory; Count III alleged defendants had waived any right not to offer COBRA continuation; and finally Count IV alleged the failure of the plan administrator to carry out his duty. App. 14a.

Plaintiff moved for summary judgment on liability issues. App. 25a. Mr. Geissal filed an uncontested affidavit. App. 28a. While the motion was under submission Mr. Geissal died, and the current appellant substituted. App. 34a. The Magistrate Judge denied summary judgment to plaintiff, but granted summary judgment *sua sponte* to Respondents on Counts I and II, leaving open the other two counts. App. 35a. The district court then ordered the Clerk to enter final judgments with the appropriate findings under Rule 54(b), FRCP, on Counts I and II, in favor of Respondents and against the Petitioner. App. 56a. Final judgment on Counts I and II were then entered. App. 58a. The United States Court of Appeals for the Eighth Circuit affirmed the judgment.

C. Statutory And Interpretive History

To put this case in proper context, it is appropriate to set forth the history of legislative and judicial development of the issues in

this case. The Eighth Circuit's analysis in *Geissal* consisted essentially of a choice between "at least two separate and irreconcilable interpretations of the law." 114 F.3d at 1465. After setting forth its view of these developments, 114 F.3d at 1461-63, the Eighth Circuit chose in favor of a formulation developed by the Eleventh Circuit, 114 F.3d at 1463, and substantially modified by several district courts which purported to follow the Eleventh Circuit approach. 114 F.3d at 1464-65 ("Upon reflection, and with the benefit of several years of case law developing the relevant standard, . . ."). In reaching this result, the Eighth Circuit explicitly rejected the approach adopted by the Seventh and Tenth Circuits. 114 F.3d 1462-63. Because the Eighth Circuit's decision relies almost exclusively on developments in other cases, the key to comprehending the Eighth Circuit approach is understanding this history.

1. Original Statute

As originally enacted, the statutory provision at issue read as follows:

> Section 602(2) PERIOD OF COVERAGE — The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
>
> * * *
>
> D. REEMPLOYMENT OR MEDICARE ELIGIBILITY. — The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) a covered employee under any other group health plan. . . .
>
> * * *

> E. REMARRIAGE OF SPOUSE. — In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

As part of the Tax Reform Act of 1986, which it enacted only a few months later, Congress sought to revise this language to make it clear that any after-acquired group health care — such as when a spouse obtains employment and group coverage for dependents — could terminate COBRA rights. The section thus read as follows:

> D. GROUP HEALTH PLAN COVERAGE OR MEDICARE ELIGIBILITY. — The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (i) covered under any other group health plan (as an employee or otherwise). . . .

There is little extrinsic evidence of what Congress intended in amending 29 U.S.C. § 1162(2)(D)(i) in 1986, but the purpose of this amendment is easy enough to discern from the language: As originally enacted, the law provided at § 1162(2)(D)(i) that continuation coverage would terminate upon an individual being first after the election covered under another plan as an employee. Section 1162(2)(E) further provided that if the individual was a qualified beneficiary by reason of being a spouse, that person's coverage would also later terminate upon being covered by another group plan through remarriage. Congress found these situations too limiting, in that there were other ways by which individuals, after making the election, could first become covered under another group health plan. For example, an eligible dependent who obtained COBRA coverage by reason of death or divorce could obtain new coverage as an eligible dependent of another's policy when the

spouse became entitled to group health coverage. So, the statue was amended and broadened to cover almost any kind of group health coverage which the participant or qualified beneficiary acquired.

2. Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir. 1989) ("Oakley"), cert. denied, 494 U.S. 1082 (1990)

The facts in *Oakley* were straightforward. The plaintiff in that case had been covered on a group plan through his employer until he was severely injured in an automobile accident. After some time, he was declared ineligible for further coverage through his employer, and he sought to elect COBRA continuation coverage. The City of Longmont, however, denied his request because he was already covered as a dependent on his wife's policy.

Because Mr. Oakley had suffered a qualifying event and was an appropriate candidate for continuation coverage, the Tenth Circuit in *Oakley* dissected the language of 42 U.S.C. § 300bb-2(2)(D)(i) — which is the state and local government version of the language here at issue in 29 U.S.C. § 1162(2)(D)(i).[2] After first noting that the requirement that the disqualifying "other group" coverage must first cover the individual "after the date of the election", the court held that the language surely must mean what it says:

> [W]e believe the plain meaning of this subsection cannot be construed to include a spouse's pre-existing group plan as a condition to terminate continuation coverage. Indeed, Mr. Oakley did not

2. The *Oakley* court actually reviewed 42 U.S.C. § 300bb-2(2)(D)(i) which relates to continuation coverage provided by government entities, but the court noted that parallel language exists in Title 29 (ERISA) under which *Lutheran Hospital* and this instant case were brought. COBRA covers more than plans subject to ERISA. *See McGee v. Funderburg, infra.*

> "first become" covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employee's termination to become a condition triggering "other coverage" under a spouse's pre-existing group plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent. 890 F.2d at p. 1132.

The court verified this conclusion through an exploration of the legislative history behind this particular language. It first examined the history of the provision as contained in a House Conference Report, and concluded that continuation coverage would terminate the day ***after*** the terminated employee obtained other coverage through employment, reemployment, or remarriage, but only if these events occurred after the individual had first elected continuation coverage. By implication, the *Oakley* court observed, coverage which was in place through marriage ***before*** the continuation coverage was elected would not impair the ability of the participant to continue his coverage from the former employer.

The Tenth Circuit then went on to speculate about the intent of Congress based on "a reading of the statute as a whole." 890 F.2d at 1132. The lower court in the *Oakley* case had acted in the belief that Congress "was concerned with providing minimal coverage and avoiding overlapping continuation coverage". 890 F.2d at 1133. But in reversing its district court the Tenth Circuit in *Oakley* held that Congressional intent as expressed in the statute was that the participant should be entitled to coverage identical to that which he or she had enjoyed prior to the qualifying event, until the securing of other coverage through a subsequent event, such as remarriage or other employment, terminated the continuation rights. The court then went on in *dicta:*

> Surely the facts of this case illustrate the precise gap in coverage which troubled Congress. Mr. Oakley was terminated because of a catastrophic event which would have put his family at risk and jeopardized his treatment had the continuation rules not been in effect to maintain his rehabilitation for a limited period of time.

890 F.2d at 1133. Thus, the *Oakley* court confronted a situation in which the participant's serious condition would not have been covered by the spouse's pre-existing coverage, but it did not rely on that fact in reaching its decision; rather, it adhered to the plain language of the statute in finding that such coverage did not preclude continuation coverage for the plaintiff.

3. Revised Statute

Ten days after the Tenth Circuit's decision in *Oakley*, the clause was amended for the last time before the facts in this case arose to read as follows:

> D. GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMENT.— The date on which the qualified beneficiary first becomes, after the date of the election —
>
> > (i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. . . .

Nothing in the statute or legislative history suggested that this new language had anything to do with the Tenth Circuit's decision or dicta in *Oakley*. Nevertheless, the legislative history of the amendment does suggest that *Oakley* correctly perceived the intent of the 99th Congress — which passed the law — at least from the perspective of the 101st Congress:

> This provision is intended to carry out the original intent of the health care continuation rules, which was to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage. If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion. If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.

H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943.

4. Brock v. Primedica, Inc., 904 F.2d 295 (5th Cir. 1990) ("Brock")

One year later, the Fifth Circuit in *Brock* unwittingly began the process that led the lower courts to make an utter mess of things. The *Brock* court decided that a qualified beneficiary who resigned from her job with pre-existing coverage from her husband's policy could elect COBRA coverage only if there was a "significant gap" in the pre-existing coverage. 904 F.2d at 297. Although the *Brock* court purports to rely on *Oakley*, for a "gap" test — no such test was ever there: the Fifth Circuit simply extrapolated it from dicta. *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558, 1569 (11th Cir. 1991) (noting that the "gap" language arose from Tenth Circuit dicta, and criticizing the Fifth Circuit's reasoning in *Brock*). The Fifth Circuit also relied on the "gap" references in the House committee report regarding the 1989 amendments set forth above. The problem was — of course — that these amendments — which created an exception to termination for pre-existing *conditions* — did not address the question *Oakley* resolved concerning whether COBRA benefits could be terminated due to pre-existing *coverage*.

No mention of any "gap" appears anywhere in any statute. *Brock* ignored the main thrust of *Oakley*: the plain language of the operative provisions of the statute — which remained unchanged — required the continuation of benefits despite pre-existing coverage.

Fortunately for Karen Brock, there was actually no difference between the benefits she would have received under the COBRA policy and what was actually paid under her husband's policy. Elsewhere, the "gap" test would make a difference.

5. National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc., 929 F.2d 1558 (11th Cir. 1991) ("National Companies")

In *National Companies* the participant and his wife paid out approximately $6,700 in medical expenses related to the birth of twins which would otherwise have been covered by the participant's insurance. The participant was saddled with responsibility for payment because the participant's COBRA coverage was terminated as a result of the wife's pre-existing plan. 929 F.2d at 1571.

Relying on titles in the legislative history of the Tax Reform Act of 1986 which amended § 1162(2)(D)(i), the Eleventh Circuit claimed in *National Companies*, that Congress intended for the termination of COBRA rights to occur:

> upon coverage by [an]other group health plan *rather* than upon re-employment or remarriage. Thus, it appears that Congress intended that the obtention, in any manner, of almost any group health coverage would justify and ERISA-plan sponsor's termination of continuation coverage, and that Congress amended ERISA to effectuate this intent. In the absence of a clear expression by Congress contrary to this position, we will not follow the Tenth Circuit's lead in limiting the plainly expansive language of ERISA.

929 F.2d at 1570-71 (citations omitted) (emphasis by court).

Thus, reaching deep for first principles, the Eleventh Circuit bases its decision on the premise that Congress broadly drafted the expansive language in COBRA and ERISA to effectuate the purpose of *denying* insurance coverage to qualified beneficiaries. This is a remarkable finding given that COBRA by its effect, and ERISA by its terms, seem to have been designed primarily to protect, not employers, but working people. *See, e.g.*, 29 U.S.C. § 1001(b). Perhaps mindful of the surprising nature of this finding, and concerned about the rather harsh consequences this principle would cause if taken to its logical conclusion, the *National Companies* court completely reverses course in the next paragraph. Finding that where there is a "significant gap" in coverage:

> the employee is not truly "covered" by the preexisting group health plan, as that term is used by Congress to effectuate its intent; the employee, despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment. Denying coverage in that setting would serve to frustrate, rather than foster, Congress' clear intentions.

929 F.2d at 1571. Nevertheless, the Eleventh Circuit decided that the $6,700 sum ***did not*** constitute a "significant gap" in coverage, because this sum was created by the lack of dual coverage, rather than a difference in the terms of the respective plans.[3]

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3. Interestingly, the Eighth Circuit held for this case that a $7500 sum would be sufficient to create a "significant gap" if it were the consequence of a difference in the terms of two plans. *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994).

The Eleventh Circuit's decision is as paradoxical as it is perplexing: First the Eleventh Circuit invents an intent to deny coverage in almost every situation where there is dual coverage through what, to say the least, is an aerobic exercise in statutory construction. Then, while seeming to entirely disagree with the Fifth Circuit's reasoning in *Brock*, the Eleventh Circuit creates a completely contrary legislative intent out of whole cloth as a gloss on the term "covered" — which preceded any COBRA amendment — in order to justify the Fifth Circuit's mistaken "gap" approach. 929 F.2d at 1569. *See Lutheran Hospital of Indiana v. Business Men's Assurance Co. of Am.*, 51 F.3d 1308, 1313-14 (7th Cir. 1995). It then defines the concept of "significant gap" not in terms of whether the second policy would cover significant costs that otherwise would be absorbed by the qualified beneficiary, or whether the beneficiary "is willing to elect health insurance continuation coverage from a previous employer as well [as preexisting coverage]," H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943, but whether coverage under the participant's plan alone would put the family in a better position than coverage under the spouse's plan. 929 F.2d at 1571.

6. The National Companies Progeny

Without any legislative warrant or guidance as to how to carry out the *National Companies* analysis, courts adopting the Eleventh Circuit's "significant gap" test began to set out to compare the adequacy of different policies as if they were alternatives when they were not. This led to a variety of methods of analysis and results which certainly would have surprised the Congressional supporters of COBRA, of which the following are examples:

- In *Lutheran Hospital of Indiana v. Business Men's Assurance Company of America*, 845 F. Supp. 1275 (N.D. Ind. 1994), *reversed*, 51 F.3d 1308 (7th Cir. 1995), the court applied the *National Companies* analysis to find that a $35,000 personal patient liability created by a $250,000

annual limit in the terms of the alternate insurance policy was not a "significant gap" in coverage — even though the COBRA plan contained no annual limit — because the significance of this difference between the two policies would not have been apparent at the time the employee elected COBRA coverage. 845 F. Supp at 1288-89.

- The court in *Daniel v. Master Health Plan, Inc.*, 864 F. Supp. 1399 (S.D. Ga. 1994), relied on *National Companies* and the district court's decision in *Lutheran Hospital* to hold that an $800,000 shortfall in coverage for treatment incident to a catastrophic accident did not create a "significant gap" in coverage because the relevant differences in exclusions and limitations between the two plans were not based on a preexisting condition of the beneficiary.[4] *Id.* at 1406.

- In *Taylor v. Kawneer Co. Comprehensive Medical Expense Plan*, 898 F. Supp. 667 (W.D. Ark. 1995), the court relied on the *National Companies* analysis — as further extrapolated by *Daniel* — to find that no "significant gap" was created by a provision in the pre-existing plan imposing a $100,000 cap in benefits for newborns, even though this created a $121,000 patient liability incident to an infant's premature birth.

- Finally, in *Liberty Life Assurance v. Toys "R" Us, Inc.*, 901 F. Supp. 556 (E.D.N.Y. 1995), the court — purporting to rely on *National Companies* — held that the "significant gap" must be caused specifically "by a limitation on coverage for a pre-existing condition," *id.* at 564, in order to prevent the termination of benefits under COBRA, thereby imposing substantial liability for $153,000 in bills related to an autologous bone marrow transplant on the otherwise qualified beneficiaries and their subrogees.

4. The court nevertheless found that the shortfall was covered under an estoppel theory. 864 F. Supp. at 1407.

Curiously, this line of cases — as developed in the lower courts — did not assign any meaning to the original language of paragraph 1162(2)(D), concluding in essence that its meaning could only be derived from the 1989 amendment to clause 1162(2)(D)(i) regarding "exclusion[s] or limitation[s] with respect to any pre-existing condition of such beneficiary. . . ." Yet the none of the potential "gaps" which concerned the courts in *National Hospital*, *Brock*, and *Oakley* were the result of a pre-existing condition, exclusion or limitation. *See Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308, 1314 (7th Cir. 1995) Straining to apply the logic of *National Companies*, the *National Companies* progeny abandoned the Eleventh Circuit's reasoning, which at least made pretence of referring to the language of the statute that Court of Appeals purported to be interpreting.

7. Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center, 51 F.3d 1308 (7th Cir. 1995) ("Lutheran Hospital")

Reversing the first of the *National Company* progeny, the Seventh Circuit in *Lutheran Hospital* concluded that there are two things wrong with the *National Company* analysis: (1) it ignores the prefatory language in § 1162(2)(D) which requires for discontinuation that the coverage ***first*** arise ***after*** the election; and (2) it makes a technical correction of statutory language into something it is not.

The Seventh Circuit in *Lutheran Hospital* relies primarily on what all the other cases should have: the fact that the plain language of 29 U.S.C. § 1162(2)(D) "is sufficiently clear in its context" to demonstrate Congress's intent that an employee would not lose their right to continuation coverage unless "he or she chooses after the election date to accept coverage under another group health care plan." 51 F.3d at 1312 (citation omitted). It then reviewed what Congress did in enacting and then in amending 29 U.S.C. § 1162(2)(D)(i) in 1986 to verify that the plain meaning was "reasonable" and therefore not absurd. 51 F.3d at 1312. It found

that: "[t]he statutory distinction between pre-existing and after acquired health care is reasonable [because it] facilitates the preservation of the beneficiary's health care status quo." *Id.*

The Seventh Circuit does engage in a foray into legislative history, but only as an exercise in trying to figure out and debunk "how and from where" the district court in that case, and Eleventh Circuit in *National Companies* divined an entirely contrary Congressional intent, which the Seventh Circuit notes "is not clear." 51 F.3d at 1312. The Court of Appeals points out that "there is little legislative history which illuminates Congress's intent in enacting COBRA and none which relates to the timing provision at issue here." 51 F.3d at 1313. There is certainly nothing in the legislative history to "undermine the statutory distinction between coverage accepted after election and preexisting double coverage." 51 F.3d at 1312. *Oakley* and *Lutheran Hospital* recognized that the phrase "first becomes after the election," still remained in the amended law, while *National Companies* and its progeny chose to read the amended statute as if that language had been eliminated.

In adhering to the plain language of the statute, the Seventh Circuit avoided not only a manifest injustice to the plaintiff in that case, but also avoided the "morass" into which the *National Companies* courts so willingly waded, that of determining what constituted a "gap" in coverage which would justify extension of COBRA coverage even if the qualified beneficiary had pre-existing coverage through another source, such as a spouse. 51 F.3d at 1314-15. The Seventh Circuit says these "gap" issues should not even be addressed, and that it is definitely not for the courts to make adequacy-of-coverage decisions for the worker facing what could be monumental expenses. What is compelling is the participant's perception as to whether he wants to pay a premium of up to 102% of cost, to "maintain their prior level of coverage." It is the insured "who bears the risk and pays the premium" who is

the best determiner of what is acceptable comparable coverage.[5] 51 F.3d at 1314.

Aside from being unworkable, the Seventh Circuit in *Lutheran Hospital* concluded the "significant gap" methodology is not supported in the statute. In 1989, Congress amended the subject provision in order to provide that if subsequent coverage contains a pre-existing condition exclusion, that subsequent group coverage could not terminate COBRA rights. A pre-existing condition clause is a very specific provision in any insurance policy; it cannot be expanded to contemplate gaps in coverage, exclusions, or other plan provisions which may differentiate one plan from another and render its coverage of much less value to the recipient. Congress at the time it amended the statue certainly could have included language to cover the "gap" issue, but it chose not to do so. 51 F.3d at 1314.

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5. The Seventh and Tenth Circuits were not the only courts to make this observation: In *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W. 2d 619 (S.D. 1993) the South Dakota Supreme Court, while noting a possible gap in coverage for the plaintiff if continuation coverage was not allowed, observed that the possibility of such a gap was precisely why Congress:

> subscribe[d] to the language "after the date of the election". People are to be given the opportunity to obtain new coverage without losing equivalent coverage in the interim. In other words, a person covered by both Medicare and a group health plan at termination will keep the same coverage until that person, not the insurance company, elects to choose otherwise. Therefore, if a gap in coverage occurs, it will be due to the individual purposely accepting less coverage. . . . Congress did not intend a covered employee's termination to become a condition triggering use of pre-existing coverage, whether it be Medicare or otherwise. "After the date of the election" plainly means "after". [Citations omitted]. 500 N.W. 2d at 622.

8. Geissal v. Moore Medical Corp., 114 F.3d 1458 (8th Cir. 1997)

Having detailed the history of the development of the law up to *Geissal*, it is not at all difficult to place the Eighth Circuit's decision in context. In the case at bar, after setting forth the differing judicial viewpoints on the matter at issue, the Eighth Circuit, by its own formulation, took this occasion to "explicitly follow the approach adopted by the Eleventh Circuit." 114 F.3d at 1463. Accordingly, on the strength of vague statements on the broad purposes of the statute in House committee reports, the Court found itself:

> . . . in disagreement with the Seventh Circuit's decision that continuation benefits were crafted to allow an individual to maintain his insurance "status quo." Rather, we are convinced that Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves "without any health insurance coverage."

114 F.3d at 1463 (*quoting*, H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622) (other citations omitted).

The Eighth Circuit then aligned itself with the *National Companies* progeny in: (1) adopting the "significant gap" test from cases interpreting committee reports; 114 F.3d 1464; (2) finding that the "significant gap" test as formulated by Eleventh Circuit would be too burdensome on employers because it would require a *post hoc* determination of whether termination of COBRA benefits was warranted; and (3) reformulating the "significant gap" test so that it did not pertain to the statutory language of COBRA, but to the 1989 exception, focusing on "whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may forseeably require."

114 F.3d at 1465. To avoid the effect of the term "after," the Eighth Circuit created the fiction that Ms. Geissal's pre-existing insurance coverage did not become truly effective until after Mr. Geissal's election was exercised.

Predictably, the effect was to find that Mr. Geissal's benefits could be denied. This Court's review followed:

SUMMARY OF THE ARGUMENT

The essential question in this case is the right of a terminated and dying employee to continue his health insurance coverage under the provisions of the Comprehensive Omnibus Budget Reconciliation Act ("COBRA"), incorporated as an amendment into the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1161, *et seq.*, when until that termination the employee had dual coverage by reason of existing coverage provided by his spouse's employer. The statute provides in 29 U.S.C. § 1162(2)(D)(i) that COBRA continuation coverage could only be suspended on:

> The date on which the qualified beneficiary ***first*** becomes, ***after*** the date of the election —
>
> > (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with regard to any pre-existing. (emphasis supplied)

The issue is whether the spouse's pre-existing coverage that gave plaintiff dual coverage before a COBRA-qualifying event, provides reason to excuse plaintiff's employer from continuing to assure such coverage, and if it does, under what further factors and circumstances.

The law requires that the phrases "The date on which" and "first becomes, after the date of the election — covered . . ." be

given their plain meaning. In light of the clear language of the statute at issue, it is somewhat surprising that there has been significant litigation about it. The statute clearly provides that an employee's COBRA rights terminate on the date on which he ***first*** becomes ***after*** the election date entitled to coverage under any other group plan. That is, only other group coverage which is obtained after the date of the election can preclude COBRA entitlement and selection. Definitions of the relevant terms in contemporaneous dictionaries, and the meaning of the phraseology in legal and general usage require this result. A contrary conclusion would violate the principle that courts are to give effect, wherever possible, to all provisions of a statute — a cardinal canon of statutory interpretation made particularly cogent by the underlying structure of ERISA and COBRA, of which the relevant provision is a part. The consistent use of similar phraseology elsewhere in the same section of the statute, the use of mandatory language in the underlying statute, and the fact that the provision at issue is an exception to mandatory language bolsters the conclusion mandated by the statute's plain meaning.

It cannot be said that absurd results are produced by giving the statute its natural and ordinary meaning. Reading the statute as preserving the health insurance status quo of employees and their families who experience qualifying events serves important Congressional goals of insuring the continued availability of health care in medical crises, and preventing the financial ruin of families in times of great misfortune. In contrast, reading the statute as if it contained language from congressional committee reports — as some circuits have done — leads to a host of paradoxes and absurdities.

Absent absurdity, the Court should not overturn the statute's specific provisions on the basis of some Court of Appeals' broad notions of statutory intent. The legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized. There is no legislative history that precisely discusses the meaning of the phrase in question, and the minimal general

discussion about the overall legislative purposes of COBRA contain isolated statements which both contradict and, to a far lesser extent, support Respondents' arguments. There was no indication that the language literally would thwart the obvious purposes of the act, and no conclusive statement in the legislative history that would undermine the ordinary understanding of the statutory language. Furthermore, were there doubts about the ordinary meaning of the language, the interpretation urged by Petitioner would be the better approach toward remedying the underlying policy problems which concerned Congress.

ARGUMENT

I.

THE COURT MUST INTERPRET UNAMBIGUOUSLY WORDED STATUTES BASED ON A NATURAL READING OF THE TEXT IF POSSIBLE.

"The starting point in statutory interpretation is 'the language of the statute itself.' " *Ardestani v. Immigration and Naturalization Service*, 502 U.S. 129, 135 (1991) (O'Connor, J.) (citations and parenthesis omitted). *See also Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475 (1992) (Kennedy, J.). The Court has consistently held that there is a "strong presumption 'that the legislative purpose is expressed by the ordinary meaning of the words used.' " *Ardestani*, 502 U.S. at 136 (*quoting*, *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982) (*quoting*, *Richards v. United States*, 369 U.S. 1, 9 (1962))).

"The 'strong presumption' that the plain language of the statute expresses congressional intent is rebutted only in 'rare and exceptional circumstances.' " *Ardestani*, 502 U.S. at 135 (*quoting*, *Rubin v. United States*, 449 U.S. 424, 430 (1981)). Where the statutory text is clear, respondent's burden to persuade the Court that Congress intended to create a contrary "special rule . . . is exceptionally heavy." *Union Bank v. Wolas*, 502 U.S. 151, 156

(1991) (Stevens, J.) (*citing*, *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241-42 (1989)).

II.

THE ANALYSIS NEED GO NO FURTHER THAN THE UNAMBIGUOUS TERMS OF THE STATUTE.

The plain meaning rule is the single most "cardinal canon" of statutory interpretation. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253 (1992) (Thomas, J.) The Court recently enunciated this position as follows:

> We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there. (citations omitted). When the words of a statute are unambiguous, then, this first canon is also the last: "judicial inquiry is complete."

Connecticut Nat'l Bank, 503 U.S. at 253-54 (*citing*, *Rubin*, 449 U.S. at 430; *Ron Pair Enterprises*, 489 U.S. at 241). *See also Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 475 ("[W]hen a statute speaks with clarity to an issue judicial inquiry into the statute's meaning, in all but the most extraordinary circumstance, is finished." (citation omitted)).

From this perspective, any discussion of the legislative history of a textually unambiguous statute is "a waste of research time and ink [and a] false and disruptive lesson in the law." *Conroy v. Aniskoff*, 507 U.S. 511, 519 (1993) (Scalia, J. concurring). *See also West Virginia Univ. Hospitals, Inc. v. Casey*, 499 U.S. 83, 98-99 (1991) ("Where [a statute] contains a phrase that is unambiguous — that has a clearly accepted meaning in both legislative and judicial practice — we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process.") In the face of this "cardinal

canon," contrary agency interpretations are entitled to no deference, *see, e.g., Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994); *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 476, difficult constitutional issues cannot be construed away, *Salinas v. United States*, __ U.S. __ (1997), 118 S. Ct. 469, 475 (1997), and contrary Supreme Court precedent must fall, no matter how well-established. *Hubbard v. United States*, 514 U.S. 695, 708 (1995) (Stevens, J.) (*overruling United States v. Bramblett*, 348 U.S. 503 (1955)). There is no novelty in assigning primacy to this canon: throughout its history, this Court and virtually all others have recognized this doctrine as required by the Constitution's separation of powers, and the limited nature of the judicial function. *See Bate Refrigerator Co. v. Sultzberger*, 157 U.S. 1, 37-38 (1895) (Harlan, J.) (*citing, Denn v. Reid*, 35 U.S. (10 Pet.) 524, 527 (1836) and *United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1803) (Marshall, C.J.)).

> To allow a court . . . to say that the law must mean something different from the common import of its language, because the court may think that its penalties are unwise or harsh, would be to make the judicial superior to the legislative branch of government, and practically invest it with the law-making power.

Rhode Island v. Duggan, 15 R.I. 403, 409, 6 A. 787 (1886).

III.

A NATURAL READING OF SECTION 1162(2)(D) OF TITLE 29 UNITED STATES CODE DOES NOT REQUIRE THE TERMINATION OF COBRA BENEFITS DUE TO COVERAGE UNDER A HEALTH INSURANCE POLICY BEFORE THE DATE OF COBRA ELECTION.

The operative terms of the statute are as follows:

> (2) Period of coverage.
>
> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:
>
> > . . . (D) . . . . The date on which the qualified beneficiary first becomes, after the date of the election —
> >
> > > (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary. . . .

29 U.S.C. § 1162(2)(D).

As authority to establish the "natural reading" of a term or phrase in "legal and general usage" the Court relies on contemporaneous dictionaries. *See, e.g., Gustafson v. Alloyd Co.*, 513 U.S. 561, 575-76 (1995); *Reves v. Ernst & Young*, 507 U.S. 170, 177-78 (1993); *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 477; *Gollust v. Mendell*, 501 U.S. 115, 124 (1991); *Mallard v. U.S. Dist. Court for the Southern Dist. of Iowa*, 490 U.S. 296, 301 (1989). Both legal and non-legal dictionaries define

"after" in such terms as "Later, succeeding, subsequent to, inferior in point of time. . . . Subsequent in time to." *Black's Law Dictionary*, 57 (5th Ed. 1979) (*citing*, *Cheney v. National Surety Corp.*, 10 N.Y.S. 2d 706 (App. Div. 4th 1939) (construing the word "after" in the phrase "after an accounting" as meaning "subsequent in time to"). *See also Webster's New Collegiate Dictionary*, 21 (1979).[6]

Thus, the phrase "after the date of the election — covered . . ." in the COBRA statute at issue can only be read as meaning "covered subsequent in time to the date of the election" and cannot colorably be read as meaning "covered at any time before or subsequent to the date of election."

This same inescapable meaning is obtained when one considers the term "after the date of the election" in the context of the phrase "The date on which the qualified beneficiary first becomes . . . covered. . . ." In both legal and general usage the word "become" means:

> to pass from one state to another; to enter into some state or condition, by a change from another state or condition, or by assuming or receiving new properties or qualities, additional matter, or a new character;

Webster's New Universal Unabridged Dictionary, 164 (Deluxe 2nd Ed. 1979). *Accord*, *Hislop v. County of Lincoln*, 437 P.2d 847, 850 (Or. 1968) (In Banc) (*citing*, *Webster's New International Dictionary*).

"Becomes" requires a change from one status to another. Courts have adhered to this definition, for example, in interpreting

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6. When words have more than one dictionary definition, the Court considers the context to determine which definition to apply. *Ardestani*, 502 U.S. at 135.

disability policies which provide for disability retirement benefits to an employee who "becomes . . . disabled after [a set date]." *Farr v. Fruehauf Corp.*, 258 N.W. 2d 821, 823 (Neb. 1977). Under this policy, an employee with a pre-existing injury would not "become disabled" after the effective date of a disability policy even though his doctor did not realize until after the effective date that the employee's prior condition rendered him disabled, where there was no actual change in his condition. *Farr v. Fruehauf Corp.*, 258 N.W. 2d at 823-24 (*citing*, *Hilsop*). Similarly, Mr. Geissal could not "first become . . . covered" after the date of the qualifying event because his coverage status did not change after the date of the qualifying event. Accordingly, as required by the plain meaning of the statute Mr. Geissal should have received the benefit of COBRA continuation coverage.

In addition, the fact that the word "becomes" is bolstered by the word "first" plainly shows that Congress had a date certain "after the date of the election" in mind. *See Nunn v. Washington*, 788 F.2d 617, 618-19 and n.2 (9th Cir. 1986) (words "first became due" in 11 U.S.C. § 523(a)(8)(A) suggests that Congress meant a specific date.). As used in COBRA "first" means "initially" *Black's Law Dictionary*, 371 (5th ed.) — suggesting that Congress meant continuation coverage to terminate on the specific initial date that the qualified beneficiary obtains new coverage under another group health plan "after the date of election".

Yet another significant aspect of the statutory language in question is the repeated use of the definite article in connection with the word "date." The use of the definite article in phrase: "The date . . . after the date of the election. . . ." implies that each date is "definite" and "specified by context or circumstance." *Webster's New Collegiate Dictionary*, 1199. Thus "The date" is not before, nor on the same day as the election, but must be subsequent to it. Congress's use of the words "becomes . . . covered" in this context requires that the coverage must start on a definite day ("The date . . . after") subsequent to a definite day ("the date of the election") for the exception to be operational, and not before this specific day.

The Court has been careful to respect specific temporal distinctions in statutes like the one at issue, even where the results are harsh — which they are plainly not in this case. For example, in *United States v. Locke*, the Court was called on to consider whether the owner of a mining claim on federal land abandoned the claim by filing a notice of intention to hold the claim *on* December 31st, when a statute required this document to be filed "prior to December 31 of each year." 471 U.S. 84, 88 & 93 (1985). The Court held, with respect to the statutorily specified date:

> . . . a literal reading of Congress' words is generally the only proper reading of those words. To attempt to decide whether some date other than the one set out in the statute is the date actually land abandoned the claim by filing a notice of intention to hold the claim with state officials 'intended' by Congress is to set sail on an aimless journey. . . .

471 U.S. at 93. Even though a literal reading of the statute would plainly lead a mining business to unintentionally lose a claim that had been held for over 20 years, the Court found:

> The phrase "prior to" may be clumsy, but its meaning is clear. Under these circumstances, we are obligated to apply the "prior to December 31" language by its terms. . . . We cannot press statutory construction "to the point of disingenuous evasion."

471 U.S. at 96 (*quoting*, *Moore Ice Cream Co. v. Rose*, 289 U.S. 373, 379 (1933) (Cardozo, J.)). *See also Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing*, 513 U.S. 414, 424-25 (1995) (Provision required calculation of payments "as if the 'first payment' was made not on the last day of the withdrawal year, but on the 'first day' of the next year. . . . This choice of time (a year and a day) would be an odd way to signal that one is to treat the first payment as if it occurred at the end of a cycle.").

The Seventh Circuit correctly describes the meaning of these terms and phrases in their context in *Lutheran Hospital*:

> The statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other group health plan. The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan. Nor does the statute say that a beneficiary's rights terminate when he or she becomes eligible for additional or alternative group health insurance. Therefore, an employee loses the right to continuation coverage only if he or she chooses after the election date to accept coverage under another group health plan.

51 F.3d at 1312 (emphasis in original).

Respondent, and several courts of appeal, ask the Court to read the statute as if the words "The date on which," "first becomes," and "after the date of the election" simply were not in the statute. Doing this would violate a rule of statutory construction which must be admitted to the college of cardinal canons because it is a necessary correlate to the "natural reading" rule: a statute must be interpreted, wherever possible, to give effect to all of its provisions, so that no part will be inoperative or superfluous. *United States v. Menasche*, 348 U.S. 528, 538-39 (1955) ("The cardinal principle of statutory construction is to save and not to destroy. It is our duty 'to give effect to every clause and word of a statute. . . .' ") (citations omitted). *See also Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing*, 513 U.S. at 424; *Plaut v. Spendthrift Farm*, 514 U.S. 211, 217 (1995); *Connecticut Nat'l Bank*, 503 U.S. at 254 (*quoting*, *Sturges v. Crownshield*, 17 U.S. (4 Wheat.) 122, 202 (1819)).

IV.

THE CONCLUSIONS DERIVED FROM THE UNAMBIGUOUS TERMS OF THE STATUTE ARE VERIFIED WHEN THE STATUTE IS READ THROUGH THE LENSES OF OTHER ESTABLISHED CANONS OF STATUTORY CONSTRUCTION.

A. Structure of the Underlying Statute

To bolster and verify the conclusion suggested by the natural reading of a statute, courts sometimes seek guidance from "the structure of the statute." *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 477. In this case, the provision at issue is an amendment to the Employee Retirement Income Security Act, "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests." *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 262 (1993). The assumption that Congress's choice of words was mistaken "is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.' " *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (*quoting*, *Nachman Corp. v. Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1985)). It is therefore "especially true" in cases involving ERISA that statutory text bearing on specific issues should not be allowed to yield to general notions of overall statutory purposes. *Mertens*, 508 U.S. at 261-62.

B. Use of Terms Elsewhere in Statute

"[I]dentical words used in different parts of the same act are intended to have the same meaning." *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (*quoting*, *Department of Revenue of Oregon v. ACF Indust.*, 510 U.S. 332, 342 (1994)). *See also National Credit Union Administration v. First National Bank & Trust*, 1998 WL 75036, 13 (U.S. February 25, 1998) ("similar language within the

same section of a statute must be accorded a consistent meaning"). Accordingly, the Court should consider whether the words or phrases in question can "bear the meaning placed on it by [respondents]" when they appear elsewhere in the statute in question; *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. at 478.

The phrase "after the date of" — which Respondents wish to construe into vapor — appears seven times in subsection 1162(2) alone. The absence of this phrase would turn the entire subsection into an ungrammatical and nonsensical nightmare. The Court would be left to interpret phrases like "the date which is 18 months the qualifying event" 1162(2)(A)(i) (modified by removing word "after") and "36 months the death of the covered employee." 1162(2)(A)(iii) (modified by removing word "after"). Congress presumably did not wish to restrict COBRA to layoffs which take 18 months to implement, or to the families of covered employees who take 36 months to die. Similarly, the operative phrases in this case are essential to interpreting other sections of COBRA, such as the notice provisions. *See, e.g., Branch v. G. Bernd Co.*, 764 F. Supp. 1527, 1536 & 1541 (M.D. Ga. 1991) (interpreting the phrases "*at least* 60 days duration" in 29 U.S.C. § 1165(1)(B) and "ends *not earlier than* 60 days after [the date of]" in 29 U.S.C. § 1165(1)(C) as "setting a floor below which the [COBRA] election period may not fall." (emphasis added)), *aff'd*, 955 F.2d 1574 (11th Cir. 1992). It is obvious that Congress desired that these phrases be meaningful, and the Court should be wary of any reading that would render them meaningless. *See West Virginia Univ. Hospitals, Inc. v. Casey*, 499 U.S. 83, 101 (1991) ("[I]t is our role to make sense rather than nonsense out of the corpus juris.") (Scalia, J.).

C. Mandatory Language in Statute

There are other significant indications in the text that COBRA health insurance coverage is to be provided following a qualifying event wherever possible, and that exceptions are to be read

restrictively: Section 1162(2) employs mandatory language which attempts to resolve any doubts about the continuation of coverage in favor of the beneficiary:

> The coverage *must* extend *for at least* the period beginning on the date of the qualifying event *and ending not earlier than* the earliest of the following:

29 U.S.C. § 1162(2) (emphasis added). Imperative language like "for at least," "not earlier than" and "must" are used when a legislature means "to impose a positive and absolute duty and not merely to give a discretionary power." *Minor v. The Mechanics Bank of Alexandria*, 26 U.S. (1 Peters) 46, 64 (1828) (Story, J.). *See also Mason v. Fearson*, 50 U.S. (9 Howard) 248, 259 (1850) (contrasting "may" — as possibly conferring discretionary power — with "must"); *Branch v. G. Bernd Co.*, 764 F. Supp. at 1536 & 1541. This language eliminates judicial discretion to "construe away" the statutory mandate. *Chevron U.S.A. v. National Resources Defense Council Inc.*, 467 U.S. 837, 842-43 (1984).

D. Exceptions are to be Strictly Construed

It is also notable that the language Respondents wish the Court to read contrary to its plain meaning is a "proviso" or "exception." The language of paragraph 1162(2)(D) is a proviso/exception because it restricts the operative effect of subsection 1162(2) by limiting the "the period" during which "coverage must extend." *Cf. Commerce Bank of Kansas City, N.A. v. Missouri Div. of Fin.*, 762 S.W. 2d 431, 434 (Mo. App. 1988) (a "proviso" excepts, limits, restricts, or qualifies the general terms of a statute "or [excludes] from the scope of the statute that which otherwise would be within its terms." (citation omitted)); *Murphy v. Nilsen*, 19 Or. App. 292, 297, 527 P.2d 736, 738 (Or. App. 1974). When in doubt, such provisions are to be construed in favor of the general operation of the statute, which is assumed to express the overall legislative purpose. *See, e.g., A.H. Phillips, Inc. v. Walling*, 324

U.S. 490, 493 (1945). Where there is an express exception, it comprises the only limitation on the operation of the statute, and no other exceptions will be implied. *Andrus v. Glover Const. Co.*, 446 U.S. 608, 616-17 (1980). While this argument is normally itself compelling, it is particularly so in this case given that the exception imposes a limitation on the imperative language in section 1162(2).

V.

THE COURT SHOULD ONLY OVERTURN AN UNAMBIGUOUS STATUTE IF IT YIELDS AN "ABSURD RESULT."

There is only one uncontroversial exception to the "plain meaning" rule:

> Where the plain language of the statute would lead to "patently absurd consequences," *United States v. Brown*, 333 U.S. 18, 27 (1948), that "Congress could not *possibly* have intended," *FBI v. Abramson*, 456 U.S. 615, 640 (1982) (O'Connor, J., dissenting) (emphasis added), we need not apply the language in such a fashion. When used in a proper manner, this narrow exception to our normal rule of statutory construction does not intrude upon the lawmaking powers of Congress, but rather demonstrates a respect for the coequal Legislative Branch, which we assume would not act in an absurd way.

Public Citizen v. United States Dept. of Justice, 491 U.S. 440, 470 (1989) (Kennedy, J. concurring) (emphasis in original). However, Justice Kennedy cautions:

> The exception remains a legitimate tool of the judiciary, however, only so long as the Court acts with self-discipline by limiting the exception to

> situations where the result of applying the plain language would be, in the genuine sense, absurd, *i.e.* where it is quite impossible that Congress could have intended the result . . . , and where the alleged absurdity is obvious to most anyone.

Id. at 470-71. Examples of absurd results might include a law allowing the prosecution of a police officer arresting a mail carrier for obstructing the mails, or applying a medieval law against drawing blood in the streets against a paramedic aiding an accident victim.[7] *Id.* However, applying the doctrine in recognition of something less than patent absurdity:

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7. In rare instances, courts justify overturning what might appear to be a natural statutory reading of a piece of legislation on the basis that it is purely the result of a scrivener's error or "slip of the pen" of the draftsperson. *See* Breyer, "On the Uses of Legislative History in Interpreting Statutes," 65 So. Cal. L. Rev. 845, 850-51 (1992). This type of judicial correction is more controversial than the exception based on absurdity: when there are plausible reasons for a statutory distinction, it is far more likely that the distinction was based on a policy choice — and that judicial interference with it treads on the constitutional prerogatives of the legislature. *See City of Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994) ("It is not unusual for legislation to contain diverse purposes that must be reconciled and the most reliable guide for that task is the enacted text.") "The facile attribution of congressional 'forgetfulness' cannot justify such a usurpation." *West Virginia Hospitals*, 499 U.S. at 101. Consequently, the quantum of evidence required to prove a scrivener's error is as high as it would be without the allegation, *see, e.g., United States v. Locke*, 471 U.S. at 95 ("But the fact that Congress might have acted with greater clarity or foresight does not give the courts a *carte blanche* to achieve that which Congress is perceived to have failed to do."): A more textual approach would require "a scrivener's error *producing* an absurd result," *Union Bank*, 502 U.S. at 163 (emphasis added), while a more historical approach would require a "conclusive statement" that

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> . . . creates too great a risk that the Court is exercising its own "WILL instead of JUDGMENT," with the consequence of "substitute[ng] [its own] pleasure to that of the legislative body."

Id. (*quoting*, The Federalist No. 78, p. 469 (C. Rossiter, ed. 1961) (A. Hamilton)).

VI.

A STRAIGHTFORWARD READING OF THE STATUTE DOES NOT YIELD AN "ABSURD RESULT."

As the Seventh Circuit recognized, there is absolutely nothing remotely absurd about the result of reading the statute at issue here in a straightforward manner:

> The statutory distinction between preexisting and after-acquired health care coverage is reasonable and facilitates the preservation of the beneficiary's health care status quo. The plain language of the statute dictates that an individual only loses COBRA

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would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136 & Section 8, *supra*. A bare allegation of a drafting error does nothing to aid the analysis.

In this case, there is nothing in the text of the statute or the legislative history of the specific language in question that remotely suggests a drafting error. Congress has revisited and revised the subsection in question numerous times since it enacted the words "after the date of the election," and has left these words alone even while the courts of appeal have applied their varying interpretations. Repeated congressional re-enactment of the controverted terms of a disputed statute tend to dispel any assertion that the terms were the product of a scrivener's error, or that Congress's enacted an absurd provision. *See Mallard v. U.S. Dist. Court for the Southern Dist. of Iowa*, 490 U.S. at 306-07.

> eligibility if he or she chooses to accept alternative group health insurance after the qualifying event. By the terms of the statute, the individual has the choice whether to preserve the status quo and continue the prior level of coverage under COBRA or accept alternative coverage and discontinue COBRA. In either case . . . the individual is never forced to accept a lower level of health care coverage than he or she received as an employee before the qualifying event. If on the other hand the language of the statute is ignored and preexisting double coverage disqualifies one from COBRA continuation coverage, upon termination an employee's status quo is not preserved and the level of coverage automatically drops to the level provided by the preexisting coverage as a beneficiary of the spouse's employer's plan. . . .

Lutheran Hospital, 51 F.3d at 1312.

The Eighth Circuit, however chose to ignore the plain meaning of the statutory language based on an erroneous interpretation of statements in Congressional committee reports. The Court of Appeals found that Congress was motivated primarily by a desire to ensure that terminated employees are provided only "bare-bones" coverage and not the preservation of the employee's health insurance status quo. *Geissal*, 114 F.3d at 1463. These contentions are refuted in detail below. Nonetheless, whatever one can divine of Congressional "intent" from such sources, it cannot be said that "Congress could not possibly have intended the result" of preserving the health insurance status quo of an employee who experiences a qualifying event, or that preserving this option for an employee would be "an absurdity that would be obvious to almost anyone." A Congressional intent to preserve the status quo is easily derived from the terms of the statute itself. *See Lutheran Hospital*, 51 F.3d at 1313. A qualified individual must *choose* to pay for the additional coverage that COBRA provides. 51 F.3d at 1312. This choice, for certain individuals — such as the Petitioner's

family who faced the possibility of accepting certain death, or facing financial ruin to pay for chemotherapy — may be far from "absurd." Anticipating such circumstances was not an "absurd" thing for Congress to do.

In contrast to the reasonable result one gets through a plain reading of the statute, the consequences of the interpretation invented by the Eleventh Circuit and adopted by the Eighth leads the courts to morass of questions, paradox and absurdity in trying to determine how to calculate a significant gap in coverage: "Does the magnitude of personal liability sufficient to constitute a gap depend on the ability of the individual to pay or on the overall scale of the medical expenses?" *Lutheran Hosp.*, 51 F.3d at 1314. Should the determination of whether there is a "gap" be made *ex ante* — at the peril of the family who decided to rely on COBRA for secondary coverage, or *post hoc* after the employer has already made a determination about whether termination of COBRA benefits is warranted? *Geissal*, 114 F.3d at 1464-65. If *ex ante*, as the Eighth Circuit held:

> [h]ow much information about the patient's physical and financial condition is the court to presume of the employer in making this after-the-fact comparison? Is the court to apply an objective or subjective standard, i.e. is it what the employer knew or what he reasonably should have known? . . . Must an employer utilize an actuary or medical expert to determine the likely effect of policy differences given the patient's physical condition at the time of the qualifying event?

51 F.3d at 1315. As the Seventh Circuit observed:

> This whole morass can be avoided by honoring the language of the statute and the decision of the insured as to how much coverage is adequate to her own situation.

VII.

ABSENT ABSURDITY, THE COURT SHOULD NOT OVERTURN THE STATUTE'S SPECIFIC PROVISIONS ON THE BASIS OF GENERALIZED NOTIONS OF STATUTORY INTENT.

Some cases suggest that a contrary legislative intent that is "clearly expressed" may overcome the "strong presumption" that the language of the statute expresses congressional intent in certain "rare and exceptional" cases. *Ardestani*, 502 U.S. at 136. Those cases which acknowledge this possibility would require "a conclusive statement" in an authoritative text about the meaning of the specific phrase in question that would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136. *See also Conroy v. Aniskoff*, 507 U.S. 511, 518 n.12 (1993) (Stevens, J.) (Court has no duty to enforce statute as written even "if fully convinced that every Member of the enacting Congress, as well as the President who signed the Act, intended a different result."). *But cf. Hubbard v. United States*, 514 U.S. at 708 (Stevens, J.) ("Courts should not rely on inconclusive statutory history as a basis for refusing to give effect to the plain language of an Act of Congress. . . .") Even this line of cases has become increasingly ambivalent about whether legislative history can ever be used in overturning the presumptive "plain meaning" definition of statutory terms,[8] or whether the inquiry is limited to "the text of

8. Some cases still explore the legislative history notwithstanding a finding that the meaning of a statute is clearly and unambiguously expressed in the text. These cases explain these discussions as efforts to "confirm" the intention expressed in the text, *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 209 (1994), "confirm" that Congress would not have regarded the result of a natural reading as "absurd or illogical," *Conroy v. Aniskoff*, 507 U.S. at 516, or are set forth out of indulgence for a Court of Appeals that found historical arguments persuasive. *See Curtiss-Wright Corp. v.*

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the act of Congress surrounding the word at issue, or the texts of other related Congressional Acts." *Id.* at 701 (*citing*, *Rowland v. California Men's Colony, Unit II Men's Advisory Council*, 506 U.S. 194, 199 (1993)). *Cf.* 514 U.S. at 702-03 ("Although the historical evolution of a statute — based on decisions by the entire Congress — should not be discounted for the reasons that may undermine the significance of excerpts from congressional debates and committee reports, (footnote omitted) a historical analysis normally provides less guidance to a statute's meaning than its final text. In the ordinary case, absent any 'indication that doing so would frustrate Congress's clear intention, or yield patent absurdity, our obligation is to apply the statute as Congress wrote it.' " (*quoting*, *BFP v. Resolution Trust Corporation*, 511 U.S. 531, 570 (1994) (Souter, J. dissenting))).

In those increasingly unusual cases in which the Court resorts to a detailed discussion of legislative history, the Court's precedent does not allow a departure from the dictates of specific statutory language because "the legislative goals underlying the statute," "the clearly stated objective of the [statute]" or the "broad purposes of [the statute]" . . . "would be served" by a different "functional" interpretation. *Ardestani*, 502 U.S. at 137-38. "[V]ague notions of a statute's 'basic purpose' are . . . inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Associates*, 508 U.S. 248, 261-62 (1993) (Scalia, J.) (emphasis in original) (*citing*, *Pension Benefit Guaranty Corporation v. LTV Corp.*, 496 U.S. 633, 646-47 (1990)).[9]

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Schoonejongen, 514 U.S. 73, 81 (1995). Such frolics, however useful when the textual meaning of a statute is truly in doubt, *see Connecticut National Bank*, 503 U.S. at 255, are now otherwise indulged only reluctantly, *Curtiss-Wright Corp.*, 514 U.S. at 80-81 and usually not without criticism. *See, e.g.*, *Thunder Basin Coal Co.*, 510 U.S. at 219 (Scalia, J. concurring); *Conroy v. Aniskoff*, 507 U.S. at 518-19 (Scalia J. concurring).

9. Some rather venerable contrary authority has not been

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VIII.

AN HISTOROCENTRIC ANALYSIS WOULD NOT OVERTURN THE SPECIFIC TERMS OF A STATUTE UNLESS ADHERENCE TO THE STATUTORY TERMS WOULD "THWART THE OBVIOUS PURPOSES OF THE ACT."

The burden to overcome the strong presumption in favor of a straightforward reading of the statute clearly lies with the proponent of the "special rule." *Union Bank v. Wolas*, 502 U.S. at 156.[10] Precedents that stand entirely outside of the modern reassertion by the Court of what is sometimes referred to as "literalism" or "textualism" demonstrate that it has always been extremely difficult for a party to overcome the specific terms of statutory language

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explicitly overruled, *see Church of the Holy Trinity v. United States*, 143 U.S. 457, 459 (1892) ("[A] thing may be within the letter of the statute and yet not within the statute, because it is not within its spirit, nor within the intention of the makers."), although soundly criticized. *See Public Citizen v. United States Dept. of Justice*, 491 U.S. at 472-74 (Kennedy, J. concurring). To the extent that *Church of Holy Trinity* and its progeny are inconsistent with constitutionally sound doctrine, and the repeated modern precedents of this Court, *see, e.g., Mertens v. Hewitt Associates*, 508 U.S. at 261-62; *Ardestani*, 502 U.S. at 137-38, the Court should not hesitate to dispense with them. Indeed, there probably would have been far less confusion in the lower courts in the case at bar, and other cases interpreting the statute at issue, if this Court applied the principal of *stare decisis* as consistently in the context of its announced rules of statutory interpretation as it does with other law.

10. Another reason that Respondent has the burden to prove that their interpretation of the statute should be adopted is that the statutory language at issue is an exception to the general operation of section 1162(2). *United States v. First City Nat. Bank of Houston*, 386 U.S. 361, 366 (1967) (One who claims the benefit of an exception from the prohibition of a statute has the burden of proving that his claim comes within the exception.).

with references to legislative history discussing the broad purposes of a statute. For example, in *Mansell v. Mansell*, 490 U.S. 581 (1989), Justice Marshall engages in a rich discussion of the legislative history — albeit primarily in footnotes — in a case where the court was called on to interpret the "plain and precise statutory language," 490 U.S. at 592, of the Former Spouse's Protection Act. *Id.* at 590 n.10; 591 n.11-n.13; 592 n.14; 593 n.15-n.18; 594 n.19. Nevertheless, Justice Marshall pointed out that in the face of that language, the Respondent:

> faces a daunting standard. She cannot prevail without clear evidence that reading the language literally would thwart the obvious purposes of the act.

490 U.S. at 592 (citation omitted). The Court found, just like in this case, that the legislative history "does not indicate the reason" that Congress chose to make the specific distinction at issue in that case in the way it did. *Id.*

> But the absence of legislative history on this decision is immaterial in light of the plain and precise language of the statute; Congress is not required to build a record in the legislative history to defend its policy choices.

Id.

"Because of the absence of evidence of specific intent in the legislative history" the respondent in *Mansell*, like the respondent in this case, was forced to resort "to arguments about the broad purposes of the Act." *Id.* Justice Marshall found this reliance to be misplaced because, at this general level, as is the case with almost all federal statutes, "there are statements [in the legislative history] that both contradict and support her arguments." *Id.* Justice Marshall concludes:

> Given Congress' mixed purposes, the legislative history does not clearly support Mrs. Mansell's view that giving effect to the plain and precise language of the statute would thwart the obvious purposes of the Act. We realize that reading the statute literally may inflict economic harm on many former spouses. But we decline to misread the statute in order to reach a sympathetic result when such a reading requires us to do violence to the plain language of the statute. . . . Congress chose the language that requires us to decide as we do, and Congress is free to change it.

490 U.S. at 594.

IX.

ANALYSIS OF THE LEGISLATIVE HISTORY SHOWS THAT THERE IS NO "CONCLUSIVE STATEMENT" THAT UNDERMINES THE ORDINARY MEANING OF THE LAW AND THAT ADHERENCE TO THE SPECIFIC TERMS OF THE STATUTE WOULD NOT "THWART THE OBVIOUS PURPOSES OF THE ACT."

The legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized COBRA was a massive piece of legislation which was rushed through Congress in order to reconcile the nation's budget. Although the rationale for continuation coverage had been circulating in Washington for quite some time — that something should be done to help individuals who lose their health coverage just because they lose their jobs — there were no formal hearings or detailed reports on what ultimately became the language at issue in this case. As a result, most of what one finds when attempting to discern the legislative intent behind various statutory passages from

extrinsic materials are pontifications by Congressional committees in after-the-fact reports.[11]

In this case, the Eighth and Eleventh Circuits place principal reliance on a phrase in a House Committee Report describing the general purposes of the first version of COBRA:

> The Committee is concerned with reports of the growing number of Americans without any health insurance coverage. . . .

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11. This lack of legislative history is lamented in several scholarly articles, most particularly in an article which appeared in the *Journal of Contemporary Health Law and Policy*, "COBRA: An Incremental Approach to National Health Insurance", 5 J. Contemp. Health L. & Pol'y, 141 (April, 1989). In the course of examining the place of COBRA in national health policy, author Thomas H. Somers lamented the manner in which continuation coverage became law. Under a heading entitled "COBRA: A 'Middle of the Night" Enactment?", he noted that Congress enacted COBRA "without deliberation and in the process of amending three distinct statutes", causing:

> a fair amount of regulatory confusion and bureaucratic tension. . . . Absent solid statutory or regulatory guidance for a legislative history that unravels COBRA's complexity, one commentator has asked whether COBRA was rationally considered, a "middle of the night" addition to the Budget Reconciliation Act. [Footnote omitted] Indeed some might argue that COBRA is symptomatic of Congress' growing inclination to delegate unlimited legislative authority to the other branches of government. The absence of legislative direction, of course, is where federal agencies and, inevitably, the courts are often called upon to divine legislative will.

The author then intones, presciently, "we should expect much of the same in COBRA's future".

See Geissal, 114 F.3d at 1463, *and National Companies*, 929 F.2d at 1567 (*citing*, H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622). Focusing on the word "any" in this phrase, these courts derived from this statement the principle that "Congress enacted COBRA [solely] because it was concerned about the fate of individuals who, after losing coverage under the employer's ERISA plan, had no group coverage at all." *National Companies*, 929 F.2d at 1569.

This murky phrase is a slender reed from which to dangle the argument that Congress's intent differed from what it expressed in the plain language of the statute. *See National Credit Union Administration*, 1998 WL 75036, 14 n.10. First of all, it is not the only broad statement of Congressional intent in the Committee report — or even in that sentence of the report. The statement continues that the Committee is also concerned about:

> the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay.

H.R. Rep. No. 99-241, pt. 1, at 44 (1995), *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622. The Committee also discusses its intent that:

> The coverage provided . . . would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group."

Id.

This language does not suggest that Congress was concerned solely with the subclass of persons without *any* health insurance, but also with the broader class of individuals who might not be able to "afford to pay" for hospital care as a result of the loss of their job, or another qualifying event. Certainly hospitals might not treat patients without any health insurance, but they might be

just as unwilling to treat underinsured patients in need of expensive treatments, such as Mr. Geissal, or the patients in those district court cases which terminated benefits because the employer was not on notice of the full extent of the employee's needs "at the time of election." *See, e.g., Daniel v. Master Health Plan, Inc.*, 864 F. Supp. at 1406 ($800,000 shortfall); *Taylor v. Kawneer Co. Comprehensive Medical Expense Plan*, 898 F. Supp. 667 ($121,000 patient liability incident to an infant's premature birth); *Liberty Life Assurance v. Toys "R" Us, Inc.*, 901 F. Supp. at 564 ($153,000 in bills related to an autologous bone marrow transplant). As the Seventh Circuit observed:

> The fact that Congress may have been motivated by the plight of a smaller sub-class — people without any health insurance — does not mean that in remedying the situation they necessarily limited relief to that subclass rather than the larger group, including Mary Isch, who lose jobs and all or part of their insurance.

Lutheran Hospital, 51 F.3d at 1313 n.5.

Similar observations could be made about the Committee's statements that the coverage provided should be "identical in scope" to that of "similarly situated individuals in the group." Each of the patients in the cases listed above would have been far better off had they not had a "qualifying event" before they experienced a medical crisis. Other similarly situated individuals in the group would benefit from the dual coverage they chose as members of the group, but the plaintiffs in these cases ultimately found that they could not benefit from the continuation coverage that they both chose and paid for. There is nothing "identical in scope" about this coverage.

Because they assume that it is permissible to interpret this statute in terms of broad goals expressed in the legislative history, various courts appear to have believed that they had to choose

between the broad goals expressed in this vague legislative pronouncement to determine which ones Congress "intended" to be serving — providing health insurance to those without "any" or preserving the "status quo?" The legislative history answer is probably all of the above — the most inclusive characterization being the most accurate. Thus, it would be perfectly consistent with the "broad purposes" of the act to "interpret" section 1162(2) to allow the widest range of coverage possible — were it permissible to "interpret" a statute in this fashion at all.

But these courts had it all wrong: because the statutory language is clear, the role of the courts, if any, should not have been to explore legislative intent ab initio, but simply to determine whether "the language literally would thwart the obvious purposes of the act." *Mansell*, 490 U.S. at 592 (citation omitted), or put another way, whether there is "a conclusive statement" in another authoritative text about the meaning of the specific phrase in question that would "undermine the ordinary understanding of the phrase." *Ardestani*, 502 U.S. at 136. There is no legislative history that precisely discusses the meaning of the phrase in question, and the minimal general discussion about the overall legislative purposes of COBRA contains statements "which both contradict and support [respondent's] arguments."[12] *Mansell*, 490 U.S. at 592. There is no reason for consideration of legislative history to go any farther than this.

Perhaps aware of the significance of the contradictions in the original legislative documents concerning COBRA, some courts

12. Even if it could be proved that Congress made a statutory change to achieve certain broad goals, it is for Congress to decide how to address the problem. "The fact that Congress may not have foreseen all of the consequences of a statutory enactment is not a sufficient reason for refusing to give effect to its plain meaning." *Union Bank v. Wolas*, 502 U.S. at 158 (*citing, Toibb v. Radloff*, 501 U.S. 157, 164 (1991)). "Whether Congress has wisely balanced the sometimes conflicting policies underlying [the statute] is not a question that [the Court is] authorized to decide." *Union Bank v. Wolas*, 502 U.S. at 162.

have resorted to statements in committee reports on amendments to COBRA which allegedly discuss "the original intent of the health care continuation rules." *See, e.g.*, H.R. Rep. No. 101-247, 101st Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943. However, these statements are equally broad. For example, discussion of the 1989 amendment describes the intent as:

> to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage.

Id. It then goes on to say:

> If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion.

Id. This language both posits an example of the type of problem the Committee felt needed clarification, and identifies the precise problem the amendment would clarify. However, there is no indication at all that in specifying this problem, the Committee limited its own concept of a "significant gap" to circumstances involving pre-existing conditions. In fact, the language of the report defines it much more broadly:

> If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.

Id. Thus, the final, very particular 1989 amendment to the statutory clause appears to have been intended to rectify the problem of disqualifying group coverage acquired after the date of election, in which the participant would not be eligible for the benefits which he or she most needed, *i.e.*, for a pre-existing illness.

Congress left the statutory language we are concerned with in this case alone — even though they had a clear opportunity to change or eliminate it. There was no indication that "the language literally would thwart the obvious purposes of the act," *Mansell*, 490 U.S. at 592 (citation omitted), and no "conclusive statement" in the legislative history that "undermine[s] the ordinary understanding" of the statutory language *Ardestani*, 502 U.S. at 136. Moreover, even if the committee report contained such statements, the Court would not give them effect without a corresponding change in the statutory language because the views of a subsequent Congress form a "hazardous basis for inferring the intent of an earlier" one. *Pension Benefit Guaranty Corp. v. The LTV Corp.*, 496 U.S. 633, 650 (1990) (*quoting, United States v. Price*, 361 U.S. 304, 313 (1960)). *See also Waterman Steamship Corp. v. United States*, 381 U.S. 252, 269 (1965); *United States v. Wise*, 370 U.S. 405, 411 (1962)).

One final argument in Respondent's opposition to Certiorari probably must be briefly addressed. Respondents assert that the statute in question must not have a "plain meaning" because some appellate judges have interpreted it in a manner that contradicts the interpretation urged by Petitioner. *Respondent's Brief in Opposition*, at 4. This is the height of circular logic, and a quite dangerous example of it. If this argument were accepted, then no statute — no matter how clear — could be interpreted by its plain terms so long as one judge could be found to disagree with the plain interpretation. It is notable that in most of the above listed cases which this court has held that the "plain meaning" of a statute governs, some lower court judge, or a Justice on this Court, has found a basis to question or disagree with the Court's interpretation of the statute's plain meaning. Respondent's argument would render the United States statutes a virtual nullity, and cause the bar to replace their volumes of the United States Code with copies of congressional committee reports. Like statements by congressmen and committees, statements by courts and judges after the language of an act in question was passed "are not a reliable indicator of what Congress intended when it passed the law, assuming

extratextual sources are to any extent reliable for this purpose." *Gustafson v. Alloyd Co., Inc.*, 513 U.S. at 579.

X.

PUBLIC POLICY CONSIDERATIONS SUPPORT THE INTERPRETATION URGED BY PETITIONERS.

Some authority exists for the proposition that a court may look to considerations of public policy where a statute is unclear and or silent about an important issue that faces the court. There is nothing unclear about the statute at issue in this case. Nevertheless, several courts of appeals — including the Eighth Circuit — have treated the statute as if it was unclear to arrive at a result that contradicts the plain meaning of the statute.

Because the language of the statute is clear, we believe that a detailed discussion of public policy is unnecessary. Nevertheless, mindful that some courts of appeal seem to have put such great stock in these arguments that they felt compelled to dispense with the text, Petitioner would be remiss if she did not mention the strong public policy arguments that support her position.

There are many good reasons why Congress would not want to see citizens lose one health care policy because of a loss of employment (or other enumerated causes), even if they have other coverage. These reasons are either clearly expressed, or effectively implied in the above referenced legislative documents: Congress did not want families to go without hospital treatment because, as a consequence of termination, they no longer have adequate insurance, as hospitals may not be willing to make up the difference. Congress was probably concerned about the potential impact on families of absorbing even part of the cost of a medical crisis, when treatment for an individual can reach into the hundreds of thousands , and sometimes into the millions of dollars. *See, e.g., Daniel*; *Taylor*; *Liberty Life Assurance*, *supra*. Congress wanted COBRA to operate in a manner consistent with principles of giving

families experiencing qualifying events equal opportunities to health care coverage as those who remained in the group, *see Oakley*, 890 F.2d at 1133 ("[T]he statute speaks only in terms of identical coverage to be made available for a limited time. . . .") and the opportunity to exercise informed choice as to whether maintaining dual coverage is worth paying 102% of the total insurance cost. For many individuals who following a qualifying event might find themselves with only one health care plan, secondary coverage is not a "luxury," *Lutheran Hosp.*, 845 F. Supp. at 1287, but the difference between life and death, subsistence and financial ruin.

In making these decisions, it is important to recognize that pre-existing conditions are not the only reason that families might choose to maintain dual coverage. Today, at least:

> . . . 75% of insured American workers and their beneficiaries receive their health care through some type of "managed care" plan. As a strategy to control costs, most managed care plans perform utilization review prior or concurrent to a proposed course of treatment to determine if it is medically necessary. "By its very nature, a system of prospective decision-making influences the beneficiary's choice among treatment options. . . ." [I]n the managed care context, the wrongful denial of benefits by an insurer — whether intentional or the result of negligent medical decisions made during the utilization review process — will sometimes result in the beneficiary never receiving the treatment that she requires, and thus can lead to damages far beyond the out-of-pocket cost of the treatment at issue.

Andrews-Clarke v. Travelers Ins. Co., 21 Employee Benefits Cases 2137, 2146-74 (D. Mass. October 30, 1997) (citation omitted). Thus, some families maintain dual or secondary coverage, not only because of the possibility of significant

"gaps" due to deductions or exclusions from coverage, but because they want to be able to avoid the tender mercies of the "gatekeeper." Whether this is a "luxury" is certainly debatable — but if it is, it could be a luxury that Congress could reasonably want families to have.

The Court has recognized that certain principles govern the interpretation of remedial legislation — which — if there is to be any "interpretation" — bears consideration:

> Any exemption from such humanitarian and remedial legislation must therefore be narrowly construed, giving "due regard" for the plain meaning of statutory language and the intent of Congress. To extend an exemption to other than those plainly and unmistakably within its terms and spirit is to abuse the interpretive process and to frustrate the announced will of the people.

A.H. Phillips, Inc. v. Walling, 324 U.S. at 493, 65 S. Ct. at 808 (quotations added).

CONCLUSION

For the reasons outlined above, the decision of the Eighth Circuit should be reversed, and the case remanded for entry of an appropriate order, and further proceedings on the remaining counts of Petitioner's complaint.

Respectfully submitted,

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(8)

No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR RESPONDENTS

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STATEMENT OF THE CASE

The instant appeal has a paucity of factual controversies but a myriad of complex and interesting legal issues involving COBRA continuation coverage when a former employee has an existing policy of medical insurance covering pre-existing conditions when his employment ends. Ironically, the former employee here has suffered no economic damages from Respondents' actions, and, in fact, is in a better financial position now than he would have been if he had received COBRA continuation coverage.

Petitioner's husband brought this action in four counts. Count I, the only Count before the Court, essentially alleges that he was a covered employee under the Moore Medical Group Health Plan, that his employment was terminated on July 16, 1993, that his COBRA continuation coverage was terminated and that this termination was improper because there was a difference ("gap") in character between Respondents' plan and Petitioner other group medical insurance plan. (App. pp. 14a-24a) The Respondents fully answered the Complaint and set forth ten (10) affirmative defenses as well as denying that the Petitioner's other group health plan underwritten by Aetna was secondary. Neither the Petitioner's employer, TWA, nor its medical insurer, Aetna Health Plans, is a party to this litigation.

Petitioner has made no claim that Aetna failed to pay any of the health claims during the COBRA continuation period. In fact, all of the claims were fully paid by Aetna. The only out of pocket expense Petitioner could conceivably have incurred was a weak allegation that the yearly deductible under the Aetna plan was "about" $350 greater than under the Moore plan[1].

1. Even this allegation is without evidentiary support. The record before the Court does not evidence that Petitioner incurred a higher deductible expense.

(App. 29a) This deductible difference is substantially less than what Petitioner would have spent to maintain COBRA continuation insurance under the Moore plan, as more fully discussed infra.

SUMMARY OF ARGUMENT

Under COBRA, a group health plan has the right to terminate continuation coverage to an otherwise qualified individual if that individual has a pre-existing health insurance provided by another group health plan. This is in keeping with the plain language of the Act, the intent of Congress as readily gleaned from the statute itself, the legislative history and the better reasoned decisions of three different appellate circuits.

COBRA was passed to give short-term protection to employees from the drastic consequences that can flow from losing their group health coverage due to an adverse employment consequence. Congress was also mindful of the cost burdens of this legislation to plan sponsors, and accordingly, has given them expansive powers to terminate COBRA continuation coverage. The case presents just one such situation. The employee was covered by another group health plan that did not contain a pre-existing condition clause and did not have any other significant gaps in coverage. In fact, the coverage of the policies was almost identical. On the date of the COBRA election was the first time that Respondents were permitted to terminate the continuation coverage.

The statute itself is curiously sparse. It can fairly be argued that many of its provisions are murky and ambiguous. If the Court determines the termination provision to be ambiguous, the only possible result is to rule that Respondents properly terminated the COBRA coverage of Petitioner's husband. To do otherwise defeats the "coherent statutory scheme of COBRA."

Additionally, if the Court adopts the "plain meaning" espoused by Petitioner, there will be some absurd and illogical results as well as some severe violations of public policy.

In essence, what the Petitioner seeks is double recovery. This attempt at double recovery is the only plausible explanation for the maintenance of this lawsuit. The Aetna Health Plan paid all of the medical expenses. She now seeks monetary relief from Respondents for those same medical expenses. Such a result is anathema, preposterous and absurd.

The Aetna Health Plan is not a party to this litigation, and it is Respondents' position that it is a necessary party to this litigation because if Respondents owe any monies it would be to reimburse Aetna and not to give the Petitioner a financial windfall. However, Aetna is not a party since it would receive nothing from this litigation since its policy of insurance was primary to the Respondents' policy. Under the coordination of benefits provisions under both plans, Aetna and Aetna alone would be responsible for all of the covered medical expenses. Respondents would be secondarily liable and since Aetna paid all of the medical expenses there is no expense for which Respondents are secondarily liable.

ARGUMENT

I.

RESPONDENTS PROPERLY TERMINATED PETITIONER'S COBRA CONTINUATION COVERAGE BECAUSE HE HAD GROUP HEALTH INSURANCE COVERAGE WITH NO SIGNIFICANT GAP IN COVERAGE.

The principal legal issue in the instant case is whether "spousal pre-existing coverage" obviates the necessity of providing COBRA continuation coverage to an otherwise qualified beneficiary[2]. This issue has been considered by five different federal appellate circuits. *See Geissal v. Moore Medical Corp.*, 114 F.3d 1458 (8th Cir. 1997); *Oakley v. City of Longmont*, 890 F.2d 1128 (10th Cir. 1989); *National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990); and *Lutheran Hospital of Indiana, Inc. v. Saint Joseph Medical Center*, 51 F.3d 1308 (7th Cir. 1995) (J. Coffey, dissenting).

While there is not complete uniformity of opinion among these five circuits, each circuit, with the sole exception of the Seventh Circuit's majority opinion, expressly looked at the character of the pre-existing spousal health insurance. To varying

2. Petitioner raised a second question in the Petition for Certiorari concerning how courts are to determine if there is a gap in coverage. Petitioner has not briefed this issue and apparently has waived this issue. As will be shown, such waiver is understandable. It should be noted that Petitioner pled this matter as a significant gap case (Count I) and that is the pleading before the Court. App. 15a at ¶ 15. Petitioner has never sought to amend her Complaint. She did not plead the position that COBRA coverage must be given even if there is no significant gap. *Also see* Motion for Partial Summary Judgment. (App 25a).

degrees these courts have all determined whether a "significant gap" occurred between the coverage the former employee would have been afforded if given COBRA continuation coverage and the coverage under the spouse's pre-existing coverage. This is precisely what the Eighth Circuit held herein.

The well-conceived decision of the Eighth Circuit held that if pre-existing coverage exists, then the employee is not entitled to COBRA coverage unless there is a "significant gap" between the policies. Here, there is no gap whatsoever. To the contrary, Petitioner would have incurred more than two thousand dollars of additional expense if COBRA coverage had been afforded to him.

Petitioner understandably has relied heavily on the split decision in *Lutheran Hospital*, *supra*, because it is the only federal appellate decision that arguably supports her position. However, it should be noted that in that case as well as *Oakley*, supra, there was a substantial gap in coverage. Moreover, in *Lutheran Hospital* the court expressly stated that it was not concerned with cases such as the instant case, where the pre-existing coverage is "perfectly adequate". *Id.* at 1312[3]. Accordingly, this reliance is the proverbial "slender reed" discussed by Petitioner. (Pet. p. 42).

It is most telling that the only difference the Petitioner could elucidate in his affidavit between the coverage in the two medical insurance policies was the amount of the yearly deductible. The total theoretical maximum difference for the two years would be three hundred fifty dollars[4]. Petitioner's cost of COBRA coverage would have been almost three thousand dollars.

3. Even the Seventh Circuit majority gave attention to the character of the other policy while professing not to do so.

4. Because Petitioner has not asserted any out of pocket (Cont'd)

Even more telling is that the Petitioner cannot relate any factual situation (or even a hypothetical) where Aetna failed to pay, and the Respondent's plan would have paid. The reason for this is quite simple — there are no such gaps. Based upon the discovery supplied by Petitioner and Aetna Health Plans, all of the Petitioner's medical bills for "covered expenses" during the COBRA period of eighteen months were paid by the Aetna Health Plan. Petitioner has never made a claim at any stage of these proceedings that Aetna failed to pay any medical bills that Respondents would have.

Accordingly, this case is squarely on point with *Brock v. Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990) and clearly distinguishable from *Lutheran Hospital* and *Oakley, supra*. In *Brock*, the former employee participated in her employer's plan until her termination in February 1988. In addition, she was covered under her husband's group health insurance plan before and after her termination. After her termination, she sought to continue coverage under her employer's plan and paid the required premium. Her former employer denied her COBRA coverage after it discovered she was covered under her husband's policy. Petitioner brought suit for her subsequent medical bills. The appellate court affirmed the trial court's granting of summary judgment against the employer and aptly stated:

> This [1989] amendment further emphasizes Congress's concern that group health plan

(Cont'd)
expenses, we assume *arguendo* that he had to pay the Aetna $500 deductible in both 1994 and 1995 for a total cost of $1,000. If COBRA continuation insurance would have been provided, in 1995 Petitioner would have had to pay, at a minimum, the $150 deductible to the Moore health plan and the $500 deductible to the Aetna health plan for a total cost of $650. However, if any of the 1994 deductibles were incurred in the last three months of 1994, that amount would also be applied toward the 1995 Aetna deductible.

> participants and their dependents not be placed in a situation in which they suffer a gap in the character of coverage as the result of a "qualifying event" such as termination of employment. (citations omitted). In [Petitioner's] case, no such "gap" occurred. Before she left [her employer] she was covered under the [employer's plan] and her husband's plan for the type of medical problem for which she later claimed — and was paid — benefits. Thus, she was not entitled to elect continuation coverage under COBRA and, accordingly, is not entitled to the benefits she seeks.

Brock, 904 F.3d at 297.

Shortly after the *Brock* and *Oakley* decisions, the Eleventh Circuit in *National Companies, supra,* thoroughly addressed the statutory language of COBRA and the intent of Congress. In addressing the 1989 amendment that added the pre-existing condition language, the Court stated:

> This amendment, like the Oakley dicta, emphasizes the importance of the character of the coverage obtained by the beneficiary.
>
> Congress enacted COBRA because it was concerned about the fate of individuals who, after losing coverage under their employe's ERISA plan, had **no** group health coverage at all.

National Companies, 904 F.2d at 1569. [Emphasis added].

It was with this factual and legal backdrop that the Eighth Circuit determined the instant case. Concerning the interpretation of 29 U.S.C. § 1162(2)(D), the court stated:

> The quoted language was not meant to absolutely insulate from the exception persons who enjoy pre-existing insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent. In other words, it is only *after* the election date that an employee's status as a beneficiary under another group health plan will permit the termination of COBRA benefits.

Pet. App. A12. The court then proceeded to determine, using a *ex ante* analysis, that there was no significant gap and that Respondents did not violate COBRA by denying him continuation coverage.

II.

THE PLAIN MEANING OF THE COBRA LEGISLATION PERMITS AN EMPLOYER TO TERMINATE A FORMER EMPLOYEE'S COBRA COVERAGE IF HE IS COVERED UNDER ANOTHER GROUP HEALTH PLAN.

A. Statutory Construction Analysis

Obviously, since there is no gap, significant or otherwise, in coverage, the Petitioner necessarily comes before the Court to argue the sole proposition remaining available to her. Namely, that the plain language of the statute permits her double coverage and double recovery under both group health plans. Such a proposition simply has no legal support, and is frankly preposterous. The plain meaning of the statute militates against this dubious proposition. The statute clearly permits employers to terminate continuation coverage when there is pre-existing coverage under any other group health plan without a pre-existing condition exclusion.

Despite the clear and unambiguous language of the statute, Petitioner and amici have cited scores of cases for the proposition that the statute is the starting point of and the ending point absent an ambiguity or an absurd or illogical result. What they conveniently omit is that courts in construing legislation must view it as a whole and not just a snippet. A court must review the whole of an Act to determine a specific provision's meaning and the intent of Congress. *Conroy v. Aniskoff*, 507 U.S. 511 (1993) (Scalia, J. concurring). Here, Congress' intent is clearly apparent on the face of the Act without resort to legislative history or spurious "leaps of faith". The parties' failure to admit that an Act is to be construed in its context is most telling because to recognize the entirety of this most cardinal of the canons of construction obviates their belabored interpretation of the plain meaning of the Act.

Respondents will not engage in the mental gymnastics of differentiating each of the string of cases cited by Petitioner and amici involving statutory interpretation. Suffice it to say that the Respondents recognize that the exact words of the statute are controlling when sufficiently clear in context. However, in almost all if not all of the cited cases, the Court has looked to the statute as a whole to determine the plain meaning of the statute or to determine if there is an ambiguity.

> Our first step in interpreting a statute is to determine whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case our inquiring must cease if the statutory language is unambiguous and "the statutory scheme is coherent and consistent." (Citations omitted).

Robinson v. Shell Oil Co., 117 S. Ct. 843, 846 (1997) (Thomas, J.).

As the trial court properly noted, a court is required to look to the plain language of the statute, give significance to the statute as a whole, and examine the purpose and intent of a statute when deciding what its terms mean. Petitioner's App. at page 10, citing *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984); *See also In Re Graven*, 936 F.2d 378 (8th Cir. 1991) ("When interpreting a statute we look not only to the express language but also to the overall purpose of the act.")

It simply does not take a crystal ball to divine the intent of Congress in enacting COBRA and in subsequently amending COBRA three times in a manner consistent with that intent. In fact, the long and consistent history of the amendments conforming the Act to the original purpose is remarkable. Congress wanted short-term protection for employees without any or inadequate health insurance while not saddling employers with too great of a cost burden. *See National Companies*, 929 F.2d at 1569-1570. In fact, the 1989 amendment expansively increased the situations where a group health plan could terminate COBRA continuation coverage, and at a minimum, codified that courts should look to the character of the other group health plan to determine if it is adequate for the employee. Obviously, if Congress were not concerned about the cost burden on employers, it would not have provided group health plans with such a broad ability to terminate coverage. The majority in *Lutheran Hospital*, *supra*, failed to take these salient facts into consideration in making its holding.

It is apparent that Congress was faced with a number of competing interests when it enacted COBRA legislation in 1986. In the face of these competing interests, Congress' purposes in passing COBRA and the three relevant amendments are clear from even a cursory reading of the Act without resort to legislative history. COBRA was designed to protect those who

lose their coverage under a group health plan due to an adverse employment consequence. As stated previously, Congress recognized the cost burden to employers which is reflected in the short term nature of the coverage; the ability to charge a premium up to 150 percent of a plan's costs, and the expansive ability to terminate continuation coverage. Congress' intent is further illustrated by the three amendments to 29 U.S.C. § 1162(2)(D).

The 1986 amendment adding "*as an employee or otherwise*" clearly expanded the grounds for terminating coverage. In 1989 it codified the gap issue by stressing the character of the other group health plan policy when it added the language, "*which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary*". This amendment also illustrates the point that Congress' did not intend to discriminate against any group of qualified beneficiaries.

Further, the last amendment with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPA) again greatly expanded the universe of situations where plans can terminate coverage. Group health plans must credit a beneficiary with the prior coverage period in the waiting period for a pre-existing condition exclusion — which cannot extend more than twelve months. Pub. L. No. 104-191, §§ 101, 102, 401. Congress again clearly demonstrated its cost concerns with COBRA and demonstrated where the burden of that cost should be placed — squarely on the policy of the other carrier and not on the economic back of the COBRA provider.

Respondents cannot over emphasize the primary importance of the cost shifting analysis in the overall scheme of COBRA. The act is in derogation of common law, and it imposes substantial financial burdens on employers. Congress recognized

these costs concerns and accordingly, took appropriate measures to lessen the economic impact on employers, principally by permitting liberal terminations. There is a common theme throughout its history that COBRA coverage should be terminated as soon as possible and that the cost of a beneficiary's medical expenses should be shifted to the group health plan that is receiving the benefit of an employee. HIPA clearly illustrates Congress' intent in this regard. Without attaching primary importance to the cost shifting provisions of COBRA any analysis of the Act, taken as a whole, fails.

Similarly see, *Teweleit v. Hartford Life and Accident Insurance Company*, 43 F.3d 1005 (5th Cir. 1995) where the Court revisited the law on COBRA continuation coverage. After reviewing the reported cases to date, the court succinctly summarized the status of those cases:

> Brock and National Co. and, to a lesser extent, Oakley have voiced a common interpretive theme of COBRA coverage: its purpose is to eliminate gaps in insurance coverage that could accompany changes in or loss of employment. These statements are not just a theme, however, but the enacted will of Congress in language sufficiently clear to achieve its purpose.

Teweleit, 43 F.3d at 1008.

If Congress intended such an expansive and liberal reading of COBRA as urged by Petitioner, it could easily have drafted a clause concerning the liberal interpretation of the Act. Congress has often inserted provisions of this nature. Given the strength of the various competing interests involved, it is highly unlikely that failing to insert such a clause was the result of oversight or a scrivener's error. Obviously, Congress did not view this as a

situation warranting a liberal and expansive reading of the statute in favor of the beneficiaries.

Contrary to Petitioner's protestations, Respondents' position is consistent with the intent of Congress and is clearly consistent with the statutory language. The continuation coverage provisions of the Employee Retirement Income Security Act of 1974, more specifically 29 U.S.C. § 1162(2)(D) presently provides that COBRA coverage can be suspended on:

> The date on which the qualified beneficiary first becomes, after the date of the election —
>
> (v) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary [other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of Title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C.A. 300gg et seq.])][5], or
>
> (v) In the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title, entitled to benefits under title (XVIII of the Social Security Act [42 U.S.C.A. §1395 et seq.])

Under the plain terms of the statute, when a covered individual has other pre-existing coverage, his COBRA coverage can be suspended on the day he elects COBRA. This

5. Bracketed clause was not in effect at the time this cause arose.

interpretation does not ignore the plain meaning of any of the statute's terms. Petitioner's interpretation, however, relies on the fallacy that because the statute points to the first date after the date of election to determine suspension of coverage that other coverage must necessarily originate after the election date. This is a complete non-sequitur. The statute only discusses the first time when a suspension of coverage can occur[6]. It never defines when the other policy must initiate coverage. Moreover, it also should be noted that Petitioner's husband only **truly** (primarily) became covered by the Aetna Health Plan when the COBRA was terminated.

This reasonable construction of the statute does not violate any statutory construction principles and is certainly not usurping the lawmaking powers of Congress. Instead, it gives effect to the plain meaning of the statute particularly when viewed as a whole. Further, it does not require the suspension of common sense nor does it require invading the province of Congress.

This issue is somewhat analogous to the issue faced by the Court in *Milwaukee Brewery Workers' Pension Plan v. Jos. Schlitz Brewing Co.*, 513 U.S. 414 (1995) (Breyer, J.).

> . . . [T]he calculation date is none of those things; it is a date chosen simply for ease of administration; and ease of administration does *not* require choosing the same date for interest-accrual purposes.

Id. at 428. Here too, the language concerning the election date is a date chosen for ease of administration. It is axiomatic that a

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6. The government implicitly admitted as much in its Brief by arguing that that the rights to COBRA during the sixty day election period are mandatory and that it can only be suspended after the election.

group health plan cannot terminate something that has never been elected.

This statutory requirement makes sense and is consistent with the "statutory scheme" of COBRA and is consistent with other legislation. Similarly, the Americans for Disabilities Act (ADA), 42 U.S.C. § 12000, *et seq.* permits prospective employers to request a medical examination of the prospective employee only after he has already been offered a position. Then, on the basis of the medical examination, the prospective employer can rescind the employment offer if the employee fails the medical examination.

Accordingly, requiring group health plans to give COBRA notice and then terminating coverage makes imminent sense, irrespective of the specific date the coverage was obtained. Moreover COBRA requires a plan administrator to "notify the beneficiary of his rights under this subsection." 29 U.S.C. § 1166(4). The typical notice states that coverage under any other group health plan is a terminating event. The time lag allows a qualified beneficiary to review his options and seek advice if necessary. Further, without the actual notice and express election of COBRA, there would be no safeguard for employers. Former employees like Petitioner's husband, with the benefit of 20-20 hindsight, will bring lawsuits against their former employers alleging they would have elected COBRA if given the opportunity. Employers would have no defense against this after the fact declaration. This would truly be a morass if employees, using an *ex post* analysis can declare that they should have been given a COBRA election. This evil is eliminated with (1) notice of the beneficiary's rights; (2) affirmative election by the beneficiary; and (3) termination by the plan — much as it does with medical exams under the ADA.

Moreover, the election period makes sense and is not a "charade" for even those with wonderful pre-existing coverage.

COBRA does not require providing only health insurance. If a group health plan offers separate dental and/or vision plans, the beneficiary may elect any or all of the plans. *See Lutheran Hospital*, 51 F.3d at 1313. Accordingly, a qualified beneficiary with wonderful pre-existing medical coverage still has the absolute right to elect COBRA continuation coverage for the dental and/or vision portions.

Furthermore, if the plain terms of the statute mandate Petitioner's interpretation, it is remarkable that four different appellate panels have ignored this mandate. *See National Companies*, 929 F.2d at 1570. ("Thus, it is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does the coverage take effect"); *Lutheran Hospital*, 51 F.3d at 1316 (J. Coffey, dissenting) ("There is nothing in the language of this statute to suggest that termination of the right to COBRA coverage cannot occur simultaneously with the triggering of the right to coverage, if a person continues comparable coverage under a pre-existing health plan.")

Petitioner and amici required approximately 100 pages to allegedly demonstrate that the plain language of the statute supports their position. The natural inference of such lengthy protestations is that it simply does not plainly support their positions. As Shakespeare wrote: "He that doth protest too much." Lending further support to this proposition is the Government's position. In 1986 it issued its proposed regulations contemporaneous with the passage of COBRA. In those regulations pre-existing coverage and Medicare eligibility are terminating events[7]. Now some 12 years later as this issue comes before the United States Supreme Court, the Government

7. The proposed regulations issued by the Internal Revenue Service, specifically answers to questions 15 and 38. 52 Fed. Reg. 22730 (1987).

does an about face and incredibly goes to great length protesting that the statute can have only one interpretation — the one in contradiction to its long held position. The government's new position (apparently for purposes of this lawsuit) obviously should be given no deference in determining this issue. *Estate of Cowart v. Nicklos Drilling Co.*, 506 U.S. 469, 476 (1992) (Blackmun, J. dissenting). Under these circumstances the government wisely has not urged deference to its position.

How amicus curiae can argue in support of its position that the statute is a clear as possibly could be is incredulous. (AARP p. 7). It is only plainly in Petitioner's favor if one has such a bias toward employee rights that one sticks his head in the sand and ignores the language and purposes of the Act. At best, it speaks rather awkwardly.

B. Legislative History Analysis

Moreover, Respondent's position is consistent with the legislative history behind COBRA. While Respondents are not stressing the legislative history, a short review is appropriate. *See Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 81 (1995):

> Ordinarily, we would be reluctant to indulge an argument based on legislative purpose where the text alone yields a clear answer, but we do so here because it is the argument the Court of Appeals found pervasive.

Congress enacted the COBRA amendments to ERISA in response to

> reports of the growing number of Americans without **any** (emphasis added) health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay.

H.R. Rep No. 241, 99th Cong., 2d Sess. 44, reprinted in 1986 U.S.C.C.A.N. 42, 579, 622. It was also prompted by the "staggering budget deficits now facing the United States." S. Rep No. 146, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S.C.C.A.N. 42, 43.

Another reason for reviewing the legislative history is that COBRA is a curiously brief statute. It is an afterthought to ERISA with its "comprehensive and reticulated statute." *Nachman Corp. v. Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1985). This author's experience has been that the statute has not been of great assistance in answering client's questions. Since it is so brief and has created so much confusion, it is an anomaly to the remainder of ERISA[8]. Accordingly, the general rules of ERISA construction are not entirely appropriate. *Cf., American Tobacco Co. v. Patterson*, 456 U.S. 63 (1981) (White, J.) referring to the vast amount of labor that went into Title VII of the Civil Rights Act and holding that: "The plain language of § 703(h) is particularly cogent in light of the circumstances of its drafting." *Id.* at 68-69.

Thus, for Petitioner to maintain that COBRA supports her attempt to obtain duplicative insurance coverage flies in the face of Congress' purpose to help those without any coverage. As such, the Court must reject Petitioner's strained interpretation. Considering the plain meaning of the statute and the relevant legislative history, the decision of the Eighth Circuit must be affirmed.

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8. *See* footnote 11 of Petitioner's Brief. While the author was actually bemoaning the lack of legislative history for guidance, the salient point is the confusion the sparseness of the statute has created.

III.

ASSUMING *ARGUENDO* THE PLAIN MEANING DOES NOT PERMIT TERMINATION, THEN THERE IS AN AMBIGUITY THAT MUST BE RESOLVED IN RESPONDENTS' FAVOR.

The Respondents maintain that the plain meaning of COBRA permits termination of continuation coverage if there is coverage by any other group health plan. However, Respondents are not unmindful that the termination provisions of § 1162(D) could fairly be labeled by the Court to be murky or ambiguous.

> The plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole.

Robinson v. Shell Oil Co., 117 S. Ct. at 846 (1997) (Thomas, J.) citing *Estate of Cowart v. Nicklos Drilling Co.*, 506 U.S. 469, 477 (1992); *McCarthy v. Bronson*, 500 U.S. 136, 139 (1991).

Considering the split of authority among the five appellate circuits who have interpreted § 1162(2)(D), a finding of ambiguity arguably is almost mandated. Each of the circuits have reviewed the plain meaning of the section and have made differing interpretations. This is not dangerous circular logic as posited by Petitioner at page 46. If just one judge had a differing position, this argument would not be advanced. However, this section has been reviewed by at least 21 different appellate justices. Sixteen justices determined the plain meaning of COBRA permitted terminations if there was pre-existing coverage under any other group health plan while five held that it did not.

Moreover, is there any question that Congress could have been clearer and more comprehensive in drafting the COBRA legislation? *Milwaukee Brewery Workers'*, 513 U.S. at 428. Very few of its terms are defined. It does not state when, for COBRA purposes, a qualified beneficiary "becomes covered" under another group health plan. Is it when the other coverage becomes primary B which is what it clearly is for those who receive insurance only after the election date? Is it for COBRA purposes the exact moment that the election is made? Strong arguments can be made to support each of these meanings. Or is it the Petitioner's interpretation that the policy must originate only after the election date? Further, the statute is silent as to when the other policy has to be obtained.

> Where a statutory term presented to us for the first time is ambiguous, we construe it to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law. See 2 J. Sutherland, Statutory Construction § 5201 (3d F. Horack ed. 1943). We do so not because that precise accommodative meaning is what the lawmakers must have had in mind (how could an earlier Congress know what a later Congress would enact?), but because it is our role to make sense rather than nonsense out of the *corpus juris*.

West Virginia University Hospitals, Inc. v. Casey, 499 U.S. 83, 100-101 (1990) (Scalia, J.).

As Respondents stress throughout, their position is "coherent and consistent with the COBRA statutory scheme." Accordingly, if the statute is deemed to be ambiguous, the only sensible result is to rule that COBRA continuation coverage may be terminated when the beneficiary has other group health

plan coverage without a significant gap regardless of the artificial concept concerning the exact moment of obtention of that coverage. Any other result simply defeats the "consistent and coherent statutory scheme" of COBRA. *Robinson*, supra.

IV.

THE INTERPRETATION OF THE STATUTE POSITED BY PETITIONER YIELDS ABSURD AND ILLOGICAL RESULTS.

Petitioner's strained interpretation of the COBRA legislation not only flies in the face of the reasonably plain meaning of the Act and the intent of Congress, but also creates some absurd and illogical results. Petitioner admits at Section V of her Brief that an absurd result is an exception to the "plain meaning" rule. Adopting the position advocated by Petitioner will yield some extremely illogical results. These illogical results are best illustrated by hypothetical situations.

Situation 1:

> Employee leaves employer on January 1. On January 15, employee is given his COBRA election notice advising that he has sixty (60) days to elect COBRA continuation coverage. On February 1 employee becomes covered under his new employer's group health plan that does not contain a pre-existing condition clause. On February 2, employee elects COBRA. Under the Petitioner's interpretation, the employee would be allowed to keep his COBRA coverage since he became covered before the COBRA election. In no manner does this preserve the "status quo" or effectuate Congress' intent. It just creates another double coverage situation wherein the employee is trying to cash in on his double medical coverage.

Situation 2:

> Same situation as situation 1 above, except that on February 1, the employee turned 65 and became Medicare eligible. Note that Medicare terminations are included in the same subsection as the one before the Court. Again, the employee would be eligible for COBRA since he became eligible for Medicare before the election date.

These situations clearly demonstrate the absurd results that will flow from the interpretation urged by the Petitioner. These situations certainly do not maintain the "status quo" as argued by the Petitioner in support of her position. Nor do they support any other expressed intention of Congress. The former employee now has the luxury of two policies where before the qualifying event he only had one. There simply is no plausible argument why Congress would desire such a result. It clearly shows that Petitioner's supercilious reliance on the exact moment of obtention of the other policy to determine whether COBRA coverage may be terminated is a red herring.

It is further an absurd proposition to believe that Congress intent was to bestow a financial windfall on people with wonderful pre-existing coverage, There is no logical reason that the small subset of people with wonderful pre-existing policies are singled out for such preferential treatment. *Lutheran Hospital*, 51 F.3d at 1312. Assuming that Congress acts rationally, there is no possibility that it would have enacted legislation that discriminated so greatly in favor of such a small subset of the population. It is axiomatic that Congress is presumed not to have discriminated and to have acted reasonably. In fact, the Act contains an anti discriminatory provision requiring COBRA coverage to be identical to that provided current employees[9]. 29 U.S.C. § 1162(1).

9. The majority in *Lutheran Hospital*, 51 F.3d at 1313 (Cont'd)

Perhaps the most absurd result is in situations like the present where the employee would have the benefit of two gilt edged insurance policies and be entitled to a double recovery. Congress did not enact COBRA to create a windfall for a few beneficiaries. It passed COBRA and the three amendments to protect those without any or inadequate health insurance. That is the status quo that was preserved. Congress certainly was not concerned with this situation where the other coverage was "perfectly adequate."

V.

PUBLIC POLICY CONSIDERATIONS SUPPORT THE INTERPRETATION URGED BY RESPONDENTS.

Petitioner made an inartful and half-hearted attempt to invoke public policies reasons to support her position. She claims that Congress was "probably concerned about the potential impact on families of absorbing even part of the cost of a medical crisis." (Pet. p. 47). Such an argument is extremely curious since on the facts of the instant case, it supports the Respondents' position. Neither having double coverage or single coverage would have resulted in the Petitioner's family having to absorb any of the costs of medical treatment. The issue is not about Petitioner absorbing costs but about Petitioner receiving a windfall or which group health plan is to bear the medical costs.

However, there are good and substantial public policy reasons supporting the Respondents' interpretation. First and

(Cont'd)
mistakenly took the identical coverage requirement to extrapolate that double coverage should be permitted. The more reasoned position was cogently set forth by the Eighth Circuit below at footnote 9. (A-11).

foremost, the interpretation clearly reflects the plain meaning of the statute and gives effect to the express intent of Congress. Secondly, Congress has spoken repeatedly as to where it believes the cost burden should be placed, and as discussed earlier it is not with the COBRA provider. The cost burden should, in the first instance, be borne by the sponsor of a group health plan who is receiving an economic benefit by having a gainful, productive employee. *See Hermann v. Cencom Cable Assocs.*, Inc., 978 F.2d 978, 979 (7th Cir. 1992) ("Health insurance care as a fringe benefit for productive workers is one thing, and as a gift to persons who have been laid off or fired is another") *Also see* dissent in *Lutheran Hospital*, 51 F. 3d at 1318 where Judge Coffey correctly stated that issue is which insurance company pays the bill.

In the same economic vein, the cost to small employers of adopting Petitioner's position would be staggering. COBRA continuation coverage is extremely expensive to group health plans[10]. This is particularly so for small employers (COBRA covers group health plans as small as 20 participants) who will need to amortize the staggering cost over a small group. If the costs become too great, small employers will think seriously about whether they should continue to provide group health insurance coverage to their employees. Such discontinuations are not in the public interest or in keeping with the intent of Congress to reduce the "staggering budget deficits facing the United States". Also, it will increase the cost of COBRA continuation coverage to those beneficiaries who actually need COBRA's protection but may not be able to afford it due to the increased cost.

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10. Sarah Rudolph Cole, "Continuation Coverage Under COBRA: A Study in Statutory Interpretation," 22 N.D. Journal of Legislation 195, 198 (1996). The undersigned appreciates this excellent article by Professor Cole and acknowledges borrowing heavily from it.

It would be a incongruous result for the Petitioner to receive a windfall while the decision eventually causes untold numbers of employees to lose their health insurance coverage. The dramatic financial consequences imposed on those workers with lost insurance will ultimately flow to the government or the nation's hospitals as the medical insurers of last resort. Moreover, the idea of a double recovery is anathema to our jurisprudential thought. COBRA health insurance is not a medical lottery designed to greatly assist the few fortunate enough to have wonderful double coverage at the expense of all others.

There is another major public policy concern with the construction advocated by the Petitioner. While Petitioner and amici voice concern over the "morass" caused by employer's having to make determinations about the character of the other group health plan, a real evil lies elsewhere if the Court adopts the Petitioner's interpretation. Namely, a bidding war erupting between the COBRA provider and the sponsor of the other group health plan attempting to influence which coverage the beneficiary elects. Is it in the public interest for the other provider to "bribe" a qualified beneficiary to elect COBRA so that person's claims will not be included in its experience rating?

VI.

THE SIGNIFICANT GAP TEST IS NOT RELEVANT TO THIS CASE.

As discussed earlier at footnote 2, Petitioner has apparently waived the second issue set forth in her Petition for Writ of Certiorari, namely the application of the significant gap rule as set forth by the Eighth Circuit. Any broad discussion herein of significant gap will be dicta since there simply was no gap in this case. Accordingly, Respondents do no intend to belabor the point.

In 1989 Congress amended 29 U.S.C. § 1162(2)(D)(I) by adding, "which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary." This amendment codified that whether a plan is allowed to terminate COBRA coverage depends upon the character of policy of insurance given by the other group health plan. Accordingly, "significant gap" is not some artificially created judicial boondoggle as some have intimated but is in line with the clearly expressed purpose of the Act. In essence it is nothing more than a determination whether there is a pre-existing condition exclusion or limitation. Further, the House of Representative in its report made express reference to the term "significant gap." H.R. Rep No. 101-247, 101st Cong., 1st Sess., reprinted in 1989 U.S.C.C.A.N. 1906, 1943. Concern by Congress over the character of the other insurance is a recurring theme.

Petitioner and amici's dubious concerns over the "morass" a significant gap analysis allegedly creates for employers is noted but has no basis in fact or law. First, this is a policy issue and as such is not the province of the Court. Ironically, Petitioner and amici belabored this point *ad nauseum* in their Briefs. Secondly, an employer who wants to escape this "morass" can voluntarily provide COBRA. An employer may voluntarily offer COBRA coverage to an ineligible beneficiary since the Act only sets out minimum requirements and certainly has no prohibition against benefits greater than the minimum.

Thirdly, this "morass" is present in the much greater number of cases involving what Petitioner would refer to as health coverage only expressly written after the employee elected COBRA. The plan administrator now has to look at the coverage of the other insurance to determine whether there is pre-existing coverage and/or a gap between the policies[11]. If plans want to

11. The Government's position is extremely curious. At footnote 14, page 27, it argues that the character of the subsequent (Cont'd)

wade into this "morass", the plan administrator is trained and paid to do just that. Accordingly, this "morass" is simply not an issue of concern to the Court.

VII.

THE PETITIONER LACKS A COGNIZABLE CLAIM FOR DAMAGES OR ANY OTHER RELIEF.

Since Petitioner has no claim for compensatory damages under ERISA, she has no legally cognizable claim under Count I of the Complaint. 29 U.S.C. § 1132(A)(1)(a). Judge Noce (A-24) correctly ruled that Petitioner has no claim for compensatory damages[12]. Accordingly, the real party in interest is Aetna Health Plans and/or TWA and neither is before the Court. Respondents cannot comprehend what type of relief the Petitioner is statutorily entitled to recover from them on Count I.

In discussions with Petitioner's counsel, he has indicated that Petitioner seeks a monetary judgment in her favor and

(Cont'd)
policy is immaterial as long as there is no pre-existing condition exclusion. This argument is diametrically opposite its position in this case of preserving the status quo. According to this line of reasoning, Congress was only concerned about a pre-existing condition clause and not whether there were any gaps in coverage. In essence, significant gap is simply a determination whether there is a pre-existing condition exclusion in the other policy.

12. Petitioner correctly noted in the Memorandum to the trial court at page 19, footnote 8, that compensatory damages are not recoverable under this type of action. In fact, "make whole" is the only remedy under these types of ERISA actions. *Cf.* 26 U.S.C. § 4980B(g)(4).

against the Respondents for the full amount of the covered medical expenses.[13] She maintains this position even though all such expenses have been paid by Aetna and neither the Respondents' health plan nor the TWA health plan permits a beneficiary double recovery of medical benefits under their respective coordination of benefits provisions[14].

Arguably, if the Court were to hold that Respondents should have provided COBRA coverage to Petitioner and that such policy was **primary** to Aetna's policy, then Aetna should be reimbursed by Respondents for all "covered expenses" incurred by Petitioner during the COBRA period. However, there simply is no support for the proposition that Respondents' policy would be primary to that of Aetna's. The National Association of Insurance Commissioners holds that COBRA insurance is secondary to other coverage. (The COBRA policy only becomes primary in the event of a pre-existing condition clause and then only primary as to the pre-existing condition.) NAIC Model Rule 120. In accordance are the coordination of benefit rules adopted by both Missouri and Connecticut, the only two states with any nexus to this case. Mo. Code of State Regulations, 20 CSR 400-2.030(4)5 and Conn. Admin. Code, tit. 38 §§ 38-174-1 to 38-174-7. According to the NAIC thirty eight states have adopted the NAIC Model Rule 120. NAIC, Model Laws, Regulations & Guidelines, Vol. 1.

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13. A similar statement was raised in Respondents' Brief to the Eighth Circuit and was not rebutted by Petitioner.

14. Petitioner mistakenly believes that she is entitled to recover and retain the full amount of her husband's medical bills from Respondents. In essence, she is seeking a huge windfall. This is hardly the sort of remedial measure Congress intended when it enacted COBRA. Only this unmitigated attempt at double recovery can explain the Petitioner's motivation to prosecute a lawsuit where a successful result will cause her to pay the Respondent almost $3,000.

Since Aetna's policy is primary and since it has paid all of the covered medical expenses, there are no expenses for Respondents to pay to either Petitioner or Aetna. Accordingly, absent a determination of the primacy of Respondents' health plan, there is simply no relief that can be granted as to Count I. At best, a successful result for Petitioner herein will be a pyrrhic victory.

The Petitioner will owe Respondents Two Thousand Six Hundred Seventy Three Dollars and eighteen cents ($2,673.18) for eighteen (18) months of COBRA coverage (18 months times $148.51 per month). Accordingly, the undersigned finds it incredible that Petitioner pursues this litigation. A successful result will cost Petitioner $2,623.18 while an unsuccessful result will have no beneficial economic impact on her or on any other entity. The Petitioner's motivation can only be described as highly suspect.

Therefore, the Petitioner, having no possibility of financial reward from this litigation, lacks any recognizable basis to pursue this matter. Only Aetna and/or TWA would have any financial stake in the outcome of Counts I. Accordingly, the nature of the relief ultimately sought by Petitioner is difficult to comprehend.

Tellingly, all of the COBRA cases involving pre-existing coverage, including the one Petitioner principally relies upon, *Lutheran Hospital*, 51 F.3d at 1308 (7th Cir. 1995), had the pre-existing medical insurer as a named party.

> COBRA insurance is not, nor has it ever been intended to provide adjunct or double health insurance coverage for those who are covered under another pre-existing policy. Mrs. Isch [the Petitioner] and Lutheran Hospital are named Petitioners in this

> action when in truth and in fact, the argument is between Associated and the Teamsters, two insurance companies who are attempting to avoid the payment of her medical expenses.

Dissent, Lutheran Hospital, 51 F.3d at 1315 (J. Coffey dissenting).

Accordingly, summary judgment should be granted as a matter of law because the Petitioner lacks any recognizable claims under Count I. Otherwise, a very real possibility of a double recovery for Petitioner exists[15]. It is black letter law that a party must have a justiciable interest to protect in order to have standing to maintain a suit.

VIII.

THE PETITIONER'S AFFIDAVIT RELIED UPON SO HEAVILY BY THE PETITIONER IS INCOMPETENT, IN PART, AND SHOULD BE STRICKEN PURSUANT TO RULE 56(e) OF THE FEDERAL RULES OF CIVIL PROCEDURE.

The vast majority of James Geissal's affidavit is either speculative, conclusory or conjectural in nature and should be stricken pursuant to Rule 56(c) of the Federal Rules of Civil Procedure. (App. 28a). Judge Noce, Memorandum at page 20, correctly ruled that Petitioner's statement were "speculative at best and insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e)." Petitioner failed to appeal this issue and has, therefore, waived same. The Eighth Circuit agreed.

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15. Judge Noce ruled: "[A] determination of the case in the absence of Aetna will not subject Moore to the risk of inconsistent or double obligations." (A-26). This part of the ruling was not appealed by the Petitioner and is waived.

For these reasons this Court in making its determinations should not consider the affidavit nor the substantial majority of the facts recited in Petitioner's Brief and the Government's Brief, neither of which have any evidentiary basis.

CONCLUSION

WHEREFORE, for all of the foregoing reasons, it is respectfully submitted that the Eighth Circuit correctly affirmed Judge Noce granting of summary judgment for the Respondents and that its decision should be affirmed.

Respectfully submitted,

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No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

REPLY BRIEF FOR PETITIONER

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I. The Statutory Language — When Viewed As A Whole — Supports Petitioners' Position.

The issue in this case is whether the spouse's pre-existing coverage that gave plaintiff under two policies before a COBRA-qualifying event, provides reason to excuse the worker's employer from continuing to assure such coverage. The authorities cited by Respondents support Petitioner's contention that if the language at issue has "a plain and unambiguous meaning with regard to the particular dispute in this case" it is dispositive. *See Robinson v. Shell Oil Co.*, 117 S. Ct. 843, 846 (1997); *Conroy v. Aniskoff*, 507 U.S. 511, 514 (1993); Resp. Brief, at 9. They are constrained to assert that the "plain meaning" of this statute actually supports this interpretation. However, their brief lacks any significant argument concerning the plain meaning of the text. They rely principally[1] on the argument that the language "[t]he date on which the qualified beneficiary first becomes, after the date of the election . . . covered" 29 U.S.C. § 1162(2)(D) was merely intended to pinpoint "the first time when a suspension of coverage can occur." Resp. Brief, at 14. The idea here is that COBRA coverage can only terminate *after* it has begun. The statutory language, it is argued, simply recognizes that COBRA coverage cannot "end" before it has begun — because, Respondent's presume, coverage does not begin until the election date. Thus, the words "after the date of the election" were included solely as a matter of logical consistency. Resp. Brief, at 8.[2] Respondents propose that this interpretation is required if the Court views the legislation:

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1. Respondents also make a half-hearted argument that "Petitioner's husband only **truly** (primarily) became covered by the Aetna health plan when the COBRA was terminated." Resp. Brief, at 14. There is no statutory language which supports Respondent's argument that a person is not "truly covered" within the ordinary meaning of "covered" by a policy that provides secondary or alternative coverage. The language of section 1162(D)(i) recognizes that it is possible to be "covered" by both a COBRA policy and another group health plan which contains an "exclusion or limitation with respect to any preexisting condition. . . ."

2. The Health Insurance Association's brief relies on this same (Cont'd)

> . . . as a whole and not just a snippet. A court must review the whole of an Act to determine a specific provision's meaning and the intent of Congress. *Conroy v. Aniskoff*, 507 U.S. 511 (1993) (Scalia, J. concurring). . . . [Petitioner and amici's] failure to admit that an Act is to be construed in its context is most telling because to recognize the entirety of this most cardinal of cannons.

Resp. Brief, at 9. In fact, viewing the language of the statute as a whole utterly refutes Respondent's argument. The termination provision is part of a subsection defining the "Period of coverage" as "beginning on the date of the qualifying event and ending not earlier than the earliest of" various dates. 29 U.S.C. § 1162(2). Because coverage begins on the date of the qualifying event — and not on the election date — it is not logically necessary for an "election" to precede the termination of coverage: logically, coverage may terminate either before or after the election date, but only *after* the qualifying event.

Petitioner has no quarrel whatsoever with the principle that the statutory language is to be interpreted as a whole. *King v. St. Vincent Hosp.*, 502 U.S. 215, 221 (1991) (*quoting NLRB v. Federbush Co.*, 121 F.2d 954, 957 (2nd Cir. 1941) (L. Hand, J.)).

Thus, it is quite appropriate for the Court to consider the meaning of paragraph 1162(2)(D) in the context of subsection

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(Cont'd)

point for their argument that the language of the act is ambiguous Amicus Brief, at 9-11. Therefore, the association asserts, the statute is subject to "interpretation" using congressional committee reports and public policy arguments. What is interesting about this brief is its artfulness in finding ambiguity in specific statutory language — because it might be misread (but only if one ads the "truly covered" language Respondents believe is implied) as pertaining to the time that other coverage "truly" takes effect, *id.* at 10 — while at the same time — arguing that a committee report is unambiguous because it includes the word "any" in the most generalized statement of intent. *Compare* Amicus Brief, at 11-13 *with* Pet. Brief, at 40-45.

1162(2), as Petitioner has proposed. However, Respondents cannot, by invoking "the significance of context," import into a statute through what Justice Souter aptly describes as "quite circular reasoning" concepts from its own self-serving analysis, legislative documents, or policy arguments. *King*, 502 U.S. at 221-222. When the terms of a statute are unambiguous — as they are in this case — the only "context" that has any significance are other statutory terms. *King*, 502 U.S. at 222 & n.14.[3]

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3. Respondents remarkably rely on *Robinson v. Shell Oil Company*, 117 S. Ct. 843 (1997); *West Virginia University Hospitals, Inc. v. Casey*, 499 U.S. 83 (1990); *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206 (1984), and Judge Scalia's concurrence in *Conroy v. Aniskoff*, 507 U.S. 511 (1993) as support for a somewhat looser application of the "whole statute" approach. *See, e.g.*, 464 U.S. at 217. Resp. Brief, at 9-10, 20. However, in both *Robinson* and *Engle*, the Court was interpreting statutes that it found to be ambiguous. *See* 117 S. Ct. at 848 (Finding that the term " 'employees' . . . is ambiguous we are left to resolve that ambiguity."); 464 U.S. at 216-17 ("The Commissioner's and taxpayers' interpretations do not exhaust the possible readings of this linguistic maze. . . . Each of the possible interpretations . . . can be reconciled with the language of the statute itself."). In fact, these cases illustrate that the Court is reluctant to stray from whatever intent can be gleaned statutory language even to interpret an ambiguous statute. 117 S. Ct. at 848.

In *Conroy*, the Court considered an unambiguous statute and correctly applied the *King* analysis to conclude "the context of this statute actually supports the conclusion that Congress meant what [it said]." 507 U.S. at 515 (*citing King*, 502 U.S. at 221). The *Conroy* Court then resorted to legislative history to confirm that a literal construction was not so absurd or illogical that Congress could not have intended it 507 U.S. at 516-17. In his concurrence, Justice Scalia vehemently condemned this brief diversion into legislative history — and away from the terms of the statute. 507 U.S. at 519 ("We are governed by laws, not by the intentions of legislators.")

In *West Virginia Hospitals*, writing for the Court, Justice Scalia cogently condemned the approach to statutory interpretation advocated

(Cont'd)

There is nothing ambiguous here whatsoever: Respondents' argument is completely flawed because the period of COBRA coverage begins at the time of a qualifying event, not at the time of election. The effect of the mistaken reading urged by Respondents would be to render the statutory language in section 1162(2)(D) entirely meaningless, a result which this Court cannot allow. *See United States v. Menache*, 348 U.S. 528, 538-39 (1955); Pet. Brief, at 27.

II. Contrary "Interpretations" in Lower Courts Do Not Imply Ambiguity.

Lacking any significant textual argument, Respondents and the Health Insurance Association rely on the fall-back position that the statutory language must be ambiguous because:

> . . . this section has been reviewed by at least 21 different appellate justices. Sixteen justices determined that the plain meaning of COBRA permitted terminations if there was pre-existing coverage under any other group health plan while five held that it did not.

Resp. Brief, at 19. *See also* Resp. Brief, at 16; Brief of the Health Insurance Association, at 10-11.

(Cont'd)

by Respondents which attempts to find ambiguity on the basis of a supposed inconsistency with a "scheme" of various successive statutory enactments. 499 U.S. at 101 ("But where, as here, the meaning of the term prevents [accommodation with previously and subsequently enacted law] it is not our function to eliminate clearly expressed inconsistency of policy, and to treat alike subjects that different Congresses have chosen to treat differently. The facile attribution of Congressional 'forgetfulness' cannot justify such a usurpation.") *See* Resp. Brief, at 11 (consistency with statutory scheme of Health Insurance Portability Act), 14 (consistency with Americans with Disabilities Act), and 20 (" . . . is there any question that Congress could have been clearer and more comprehensive in drafting the COBRA legislation?" *e.g.* by defining what "covered" means).

It shows how all the judicial interpretations of section 1162(2)(D) relied on by Respondents have grown like a coral reef: polyp-by-polyp — upon the calcarious skeletons of their anthozoan ancestors — by simply adopting the reasoning or dicta of earlier decisions with little or no independent consideration of the statutory language. *See, e.g., Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1462-64 (8th Cir. 1997). Ultimately the original decisions, upon which all the others cited by Respondents grew, either gave no actual consideration to the terms of the statute, *see, e.g. Brock v. Primedica*, 904 F.2d 295, 296 (5th Cir. 1990), or conducted an exercise in lip service to the "plain meaning" rule while actually relying on whatever could be found to support the desired result from the most general and shifting of pronouncements by congressional committee staff members. *See, e.g., National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558, 1569-71 (11th Cir. 1991).

In *Hubbard v. United States*, 514 U.S. 695 (1995), the Court was recently called on to decide whether to overturn its own 40-year-old unanimous decision interpreting 18 U.S.C. § 6 and 1001, *see United States v. Bramblett*, 348 U.S. 503 (1955), which relied on its own "not completely implausable" 514 U.S. at 706, analysis of the legislative context and historical evolution of that statute. 514 U.S. at 702-703. While noting that historical analysis of previous enactments "should not be discounted for the reasons that may undermine confidence in the significance of excerpts from congressional debates and committee reports," *id.* at 703, the *Hubbard* Court held that "the [*Bramblett*] Court erred by giving insufficient weight to the plain language of 6 and 1001." Ultimately the Court's overriding obligation "to apply the Statute as Congress wrote it", 514 U.S. at 703 (*citing BFP v. Resolution Trust Corporation*, 511 U.S. 531, 570 (1994) (Souter, J., dissenting), was so strong that it surmounted the Court's formidable inhibitions about overturning its own established interpretation of a statute. 514 U.S. at 711 & 712 n.11. However, neither the majority opinion, nor even that of the dissenters in that case, gave any credence to the argument that the prior Court's incorrect reading

of the statutes was any less incorrect — or the plain meaning of the statutes any less plain — because all nine justices in *Bramblett* erred. 514 U.S. at 724 (Rehnquist, C.J., dissenting) (although *Bramblett*'s interpretation of a statute may have been "wrong, even really wrong" it "does not overcome the institutional advantages conferred by adherence to *stare decisis*. . . . This, then, is clearly a case where it is better that the matter be decided than that it be decided right.")

The policy arguments and committee report extracts cited by the lower courts supporting Respondents' position in this case provide a far less persuasive basis for ignoring the plain language of a statute than did the enactment-based reasoning of the nine Supreme Court justices in *Bramblett*. *See Hubbard*, 514 U.S. at 703. In this case, unlike self-referential body of law that has grown up in support of Respondent's position, the courts supporting Petitioner's position reached their decisions through direct and independent analysis of the terms of the statute that precisely govern the circumstances in issue. *Lutheran Hospital of Indiana v. Business Men's Assurance Company of America*, 51 F.3d 1308, 1312 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128, 1132 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990); *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W.2d 619, 622 (S.D. 1993).[4] The mere existence of contrary authority does not necessarily suggest any ambiguity in the statute: it simply shows that lower courts — are still sometimes misled by extraneous legislative materials — despite this Court's repeated attempts to steer them clear of this kind of error.[5]

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4. Moreover, these cases also represent a " 'competing legal doctrin[e]' that can lay a legitimate claim to respect as a settled body of law." *Hubbard*, 514 U.S. at 713. Accordingly, none of the constraints that made the *Hubbard* Court reluctant to overturn its own earlier unanimous decision should cause the Court any hesitation to overturn erring lower courts on the issues at bar. 514 U.S. at 713 n.13.

5. For additional discussion of these arguments, *see* Petitioner's Brief, at 46-47.

III. Helping Displaced Workers to Get Access to Medical Care Was the Primary Purpose Of COBRA.

Respondents and amici make a great deal of the fact that in enacting COBRA Congress was concerned with the cost burden imposed on employers by the legislation. Resp. Brief at 10-12; 23-25. They assert that the interest Congress was primarily concerned about in enacting — or at least amending COBRA — was reducing the economic impact of continuation coverage on employers[6] by "permitting liberal terminations." Resp. Brief, at 11-12.

Petitioner has no qualms with a presumption that the cost burden on employers was one of the "competing interests" Congress weighed in crafting the terms of the legislation. Resp. Brief, at 10. Any time a piece of legislation imposes a cost, Congress is presumptively concerned — to some extent — about who is going to pay for it. Congress plainly had cost controls in mind when it

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6. As "background" about such costs, the Health Insurance Association includes in its brief some results of a survey which allegedly shows the impact of COBRA continuation coverage. Amicus Brief, at 6-7. These survey results have never been validated, audited, or subjected to any adversarial testing. No information is provided in the survey about sampling methodology — except that there were a very low number of respondents — raising a very real possibility that those companies who responded to the survey are self-selected and not terribly enthusiastic about their responsibilities under COBRA. *See* D. Huff, *How to Lie With Statistics*, 13-21 (1954) ("To be worth much, a report based on sampling must use a representative sample, which is one from which every source of bias has been removed.") The survey does not include any comparison of those circuits (or employers) who allow employees to obtain COBRA despite the existence of pre-existing spousal coverage, with those who do not, nor does it ever define "costs," nor distinguish "administrative" costs from the actual cost of insurance policies. *Id.* at 131-135 ("[W]atch out for a switch between a raw figure and the conclusion."). The Court should be wary of reaching any conclusion from the use of social science data that has not been tested in the adversarial fires of the district courts.

permitted employers — subject to certain caps[7] — to charge ex-employees more for COBRA coverage than the total cost of health insurance prior to a qualifying event.

Nevertheless, the main purpose of COBRA and its amendments was not to reduce the cost burden of employer sponsored health insurance which continued after a qualifying event: there would have been little doubt the legislation would increase this burden to some extent, because before COBRA, employers were not required to provide these benefits. Rather, the primary motivation of the Congressional supporters of the legislation was to reduce those instances in which people are unable to obtain medical treatment due to loss of — or reduction in — insurance benefits following the occurrence of a qualifying event. Pet. Brief, at 40-50.

A recognition of the likely congressional purposes behind the legislation in no way complicates the decision rules that must be followed by this Court: To the extent that it is recognized that Congress was attempting to reconcile diverse purposes in enacting COBRA, "the most reliable guide for that task is the enacted text." *City of Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994). "Whether Congress has wisely balanced the sometimes conflicting policies underlying [the statute] is not a question that [the Court is] authorized to decide." *Union Bank v. Wolas*, 502 U.S. 151, 162 (1991). If there were any ambiguity to be found in the text, such ambiguity would be resolved bearing in mind that Congress enacted COBRA as a "humanitarian and remedial" measure for the benefit of employees, not as a cost saving legislation for businesses and employers. *A.H. Phillips v. Walling*, 324 U.S. 490, 493 (1945).

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7. Congress did not impose such caps when it passed the Health Insurance Portability Act of 1996, Pub. L. No. 104-191. Consequently, such replacement coverage is usually unaffordable to persons who might otherwise qualify for it. In addition, some insurance companies have been accused of making this insurance difficult or impossible to obtain. This is one reason why COBRA remains such an important benefit.

IV. Respondents' Assertions Regarding Windfalls; Double-Recoveries; Gaps; Secondary Coverage; and Standing Are Not Supported By The Record.

A. Respondents Mischaracterize the Record and Procedural History of this Case.

Respondents base a number of arguments on specific factual assertions about Petitioner's claims, and Respondents' duties to pay those claims versus Aetna — the health insurance provider under Ms. Geissal's group health plan. They assert that "[b]ased upon the discovery supplied by Petitioner and Aetna Health Plans," Aetna paid all of Petitioner's "covered expenses," and that "Petitioner has never made a claim that Aetna failed to pay any medical bills." Resp. Brief, at 6. The only difference between the Moore Medical policy and the Aetna policy, Respondents submit, is a $350 deductible. They posit that the effect of requiring Moore Medical to provide coverage to Petitioner would be "double recovery" — an absurd "windfall" for a few beneficiaries that could not have been intended by Congress. Resp. Brief, at 23. They assert that this means that there was no "significant gap" between the plans, which would preclude coverage by both plans under the lower court decisions that Respondents wish this Court to follow. Resp. Brief, at 25-27. Alternatively, respondents argue that if they were required to give coverage, the Court should hold that they were the secondary insurer, and therefore not required to pay any of Petitioner's claims. Resp. Brief, at 28-29. Moreover, because — in Respondent's opinion — Petitioner could gain no substantial benefit from maintaining this suit unless Petitioner gained a "double recovery" — which presumably violates some legal doctrine — it is asserted that Petitioner has no justiciable interest to give her standing to maintain this suit. Resp. Brief, at 30.

What is ignored in this cascade of factual assertions and arguments is a recognition of what issues are and are not before the Court, what facts are and are not a matter of record, and a recognition of the procedural status of the case as it reaches the

Court: While the case was pending in the district court, Petitioner — and not Respondents — submitted a Motion for Partial Summary Judgment on the sole issue of whether Respondents were obligated to provide COBRA coverage. Petitioner's Motion did not touch on what claims Respondents would be required to pay if Respondents were found to have this obligation. App. at 25a.

Petitioner argued that he was entitled to benefits as a matter of law because he had acquired no other insurance following the occurrence of a qualifying event. App. at 26a. In the alternative, Petitioner claimed that he was entitled to coverage by Moore Medical because

> a person in [Petitioner's] state of health would not have reason to believe coverage only under the preexisting spousal coverage was adequate at the time of or following the 1163 qualifying event.

App. at 26a. In support of the sole proposition that Mr. Geissal reasonably believed the Aetna policy might not be adequate, Petitioner submitted a brief affidavit, executed while he was still in the course of treatment, pointing out that he expected that his cancer would require expensive treatment, that coverage under the plans was different, that because of his illness there was a possibility that he would exceed the lifetime maximum under the Aetna plan, and that he was concerned about the reliability of the insurance under the Aetna plan. App. at 28a-32a.

In response to Petitioners' Summary Judgment motion, Respondents disagreed with Petitioner's substantive legal arguments. Respondents also asserted affirmatively without any supporting evidence that Aetna was a necessary party — and that Geissal did not have standing to pursue his claims. It was only after the parties fully briefed and submitted evidence in relation to the Motion that Mr. Geissal died, and his treatment ceased.

The district court rejected Respondent's affirmative defenses. The court found that Petitioner's equitable interest in COBRA coverage was sufficient to support standing. It also found: (1) that it was irrelevant to the issue of relief between the parties that Aetna may have paid for some of Mr. Geissal's medical treatment; (2) that Aetna did not become a necessary party simply because there was a "speculative possibility" that Aetna might have future claims to the potential proceeds of Petitioner's COBRA policy; and (3) that the question of whether the Moore or Aetna plan should be considered "primary" could be made "upon adequate [future] discovery, without Aetna's presence as a party."[8] App. at 41a-44a.

Unfortunately, the district court also decided at that time to grant summary judgment to Respondents, on the court's own motion, without prior notice to the parties, or any opportunity to submit further evidence bearing on the legal theory it decided to adopt. App. at 35a. On the law, the court found itself in unexplained agreement with *National Companies* conclusion that it could interpret away the plain meaning of the statute, and that COBRA coverage would terminate if a qualified beneficiary had pre-existing spousal coverage. App. at 48a. The court also found that the allegations in Mr. Geissal's affidavit were not sufficient to show a "significant gap" because they did not show that the Aetna policy

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8. Respondents do not contest the district court's finding that Aetna was not a necessary party. In a footnote, Respondents note that Petitioner did not contest this part of the district court's decision, and that she therefore "waived" this issue. Resp. Brief, at 30 n.15. Petitioner has no problem with the district court's finding that Aetna is not a necessary party.

Under Supreme Court Rule 15.1 and *Oklahoma City v. Tuttle*, 471 U.S. 808, 815-16 (1985), the Respondents are to put procedural issues contended to be dispositive of the case, in their opposition to the Petition for Writ. Respondents' concerns that the Petitioner is not the real party in interest (which encompasses their standing and Rule 19 objections) were not in their opposition and were therefore waived.

had an exclusion or limitation with respect to a pre-existing condition. App. at 51a.

Considering the state of the record, and the procedural posture of this case, the Court cannot assume any of the facts that Respondents have asserted to support their arguments. No proof exists in the record about (1) whether Petitioner submitted all of his medical expenses to Aetna for payment; (2) whether Aetna paid all Petitioner's expenses; (3) whether Respondent's policy would cover medical expenses not covered by Aetna; or (4) how Respondents and Aetna would coordinate their responsibilities for Mr. Geissal's medical expenses if Respondents were found to be obligated to provide coverage. These issues were not before the court on Petitioner's summary judgment motion, and Petitioner was under no obligation to submit any evidence as part of this motion bearing on these issues. Under the theory Petitioner advanced in support of his summary judgment Motion, all such evidence would be unnecessary: the dispositive issue was either the plain meaning of the law, or whether it was reasonable for him to elect COBRA coverage when he did.[9]

B. The Record Does Not Reveal Anything About The Nature of Petitioner's Claims, Coordination of Benefits Between Policies, and What "Gaps" May Remain in Coverage.

The procedural status of the case when the district court made its ruling both defines and limits the relief that this Court may provide. If the Court upholds the plain meaning of the statute, it can rule that Respondents were required to provide coverage, but cannot determine which claims they are obligated to pay because no evidence bearing on this was before the district court. The Court also cannot make any substantive determination about which insurance policy would be "primary" and which "secondary" — because this issue was not before the district court when it ruled.

9. Petitioners dispute Respondent's assertions with respect to these factual issues.

Similarly, the Court can determine whether the statute authorizes a "significant gap" test, and can set guidelines as to how the test can be applied — but it cannot rule as to the outcome of that test (assuming *arguendo* that any such is to be applied) because Petitioner has not yet been given the opportunity to introduce evidence that a significant gap existed.

Viewed in light of the above observations, Respondents' arguments regarding "double recoveries," and "windfalls" are entirely illusory. Respondents have proven nothing about their obligations to pay Petitioner if they are required to provide COBRA coverage.

C. Respondent's Observations Are Irrelevant.

Respondents' may or may not be able to show — at some point — that their obligations to pay some claims under their insurance contract are limited — to some extent — by virtue of the Aetna coverage, but that possibility has no bearing on the entirely separate question of whether or not they are statutorily obligated to provide COBRA coverage at all. Aetna may or may not have claims against Petitioner if Respondents are obligated to pay for medical expenses already paid by Aetna. But, as the district court correctly held, that is a matter between Aetna and Petitioner, which does not concern Respondents, who is not a necessary party of this litigation. App. at 44a (*citing LLC Corp. v. Pension Benefit Guarantee Corp.*, 703 F.2d 301, 305 (8th Cir. 1983)).[10] Assuming

10. The district court's finding that Aetna was not a necessary party to this litigation is fatal to their claim that Petitioner lacks standing. App. at 29. Petitioner can enforce his right to COBRA coverage — and to obtain benefits under a COBRA policy "without regard to the speculative possibility of future litigation" between Petitioner and Aetna. Respondents assert that Petitioner's motivation for bringing this suit is "highly suspect" in view of what they allege about Aetna's payments. Resp. Brief, at 29. There would be nothing improper about Petitioner seeking to recover all benefits she would be entitled to under the Moore

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that Respondents are required to provide coverage under COBRA, their obligations to Petitioner would be no greater than what they would have been if Moore Medical had not terminated Mr. Geissal.[11] Nothing about this result not absurd,[12] but it appears to be exactly

(Cont'd)
Medical Plan, even assuming *arguendo* that she is also entitled to recover for some of the same expenses under the Aetna Plan, or that she is pursuing this litigation — in part — as a nominee for Aetna.

11. It would not be necessary for the Court to alter the plain meaning of statutes, or the statutorily mandated results of a given case, to avoid the possibility of "double recovery" for medical expenses — even if there was some valid argument to support an alternate construction. If the sponsors of group health plans wish to avoid this possibility, nothing prevents them from drafting group health plans to disallow double recovery. Respondents appear to be urging the Court to read into the terms of a statute what they worry they might have forgotten to add to the terms of their own insurance policy.

12. Respondents posit several other possible scenarios which allegedly show that interpreting the statute consistent with its plain meaning would yield absurd results. Resp. Brief, at 20-21. In both of these unusual circumstances, a qualified beneficiary is able to gain COBRA coverage even though he or she elects other group health care coverage after occurrence of a qualifying event. Respondents are unable to point to any case in which a potential beneficiary has tried to obtain secondary coverage in the manner they suggest, and it is extremely doubtful that the average COBRA beneficiary would go to so much trouble to fit herself into a loophole in the act in order to gain secondary coverage after a qualifying event. Moreover, the results are not really absurd, bizarre, or even contrary to Congress's intent to assist families who experience qualifying events. Pet. Brief at 31-33. At most these scenarios show that it is possible under the statute for someone to gain secondary coverage while retaining COBRA benefits under circumstances that Congress did not fully anticipate. "The fact that Congress may not have foreseen all of the consequences of a statutory enactment is not a sufficient reason for refusing to give effect to its plain meaning." *Union Bank v. Wolas*, 502 U.S. at 158 (*citing, Toibb v. Radloff*, 501 U.S. 157, 164 (1991)).

(Cont'd)

what the Congressional supporters of COBRA intended. *See* H.R. Rep. No. 99-241, pt. 1, at 44, *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622 (noting the Committee's desire to make coverage to a discharged employee under COBRA "identical in scope to the coverage provided under the group plan to similarly situated individuals in the group."); Cong. Rec. H38286 (daily ed. December 19, 1985) (Conference Report on H.R. 3128 and 3500).

D. Respondents Misconstrue Petitioners' Position on the "Significant Gap" issue.

Respondents argue that Petitioner has waived the issue of how the Courts should approach the determination of whether or not there is a "significant gap" in coverage in applying the statute at issue. Resp. Brief at 25. She did not. She asserts that a "significant gap" test should not be used by the courts at all in cases where there is pre-existing group health care coverage.[13] Pet. Brief, at 36, 45, 48-49. In Petitioner's view, the law anticipates that it is up to the qualified beneficiary to apply their own "significant gap" test when they decide whether to elect COBRA coverage — and the Courts should respect this choice. H.R. Rep. No. 101-247, 101st

(Cont'd)
In contrast, under the analysis advocated by Respondents, if an otherwise qualified employee had, at the time of termination, secondary spousal coverage that is plainly insufficient for serious medical problems (*e.g.* $5 per medical event, an annual maximum of $500, and a lifetime maximum of $1500) without a clause excluding specific pre-existing conditions, there could be no "significant gap" allowing him to obtain COBRA coverage. This type of result is both far more bizarre — and more probable — than any hypothetical absurdity Defendants have proposed.

13. Whether a "significant gap" test is a useful framework for deciding if there is an "exclusion or limitation" 29 U.S.C. § 1162(2)(D)(i) preventing coverage for pre-existing condition in a group health plan acquired after the date of a COBRA election is beyond the scope of this case.

Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943 ("If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.") It would be irrational for qualified beneficiaries to pay for health care coverage that they did not have a good reason to want.

Respondents have proposed an alternate version of the significant gap test that would allow — first a plan administrator, and then the Courts — to decide whether there "was" a significant gap by reviewing a beneficiary's claims after the fact to determine whether there was an exclusion or limitation on a pre-existing condition. We have discussed the difficulties inherent in this approach, and argue not only that there is no support for it in the enactment, but that it is a horribly bad idea. Pet. Brief, at 35.

If, notwithstanding our arguments, the Court concludes that lower courts or plan administrators are compelled (by something Petitioner may have overlooked in the terms of the statute) to get into the business of second guessing employee COBRA elections, they should be doing it from the point of view of the employee at the time of the election,[14] not from the point of view of employers after the fact. Specifically, they should be asking the question that Mr. Geissal asked in his summary judgment motion:

> [Would] a person in [Petitioner's] state of health [at the time of election] have reason to believe coverage only under the preexisting spousal coverage was

14. The Eighth Circuit recognized the advantages of applying the "significant gap" test from the point of view of the day of COBRA election, instead of after the fact. *Geissal*, 114 F.3d at 1465. Unfortunately, it also required it to be applied based on the "information available to the employer" on that day. It would be bad public policy to require ex-employees to disclose their private projections about their own future medical condition to their ex-employers as a condition of receiving continuation coverage after the termination of employment.

> adequate at the time of or following the 1163 qualifying event?

App. at 26a.

Aside from being more workable than anything Respondents have proposed, this test, at least has several conceivable policy advantages: (1) it allows the courts and plan administrators — at their own risk — to protect employees from making completely idiotic COBRA elections; and (2) there will be far fewer circumstances giving rise to cases like this one.

In this case, Mr. Geissal believed it made sense for him to elect coverage when he was terminated from his job, at minimum, because of the tremendous costs of anticipated cancer treatment, the uncertainties of being covered under a single policy, and the lifetime maximums he faced on his wife's group coverage. These concerns are understandable, notwithstanding Respondent's representations about the outcome. The Court should not require Mr. Geissal or other COBRA beneficiaries to anticipate medical outcomes with 20-20 foresight as a condition of COBRA coverage, or to make a perfect choice when they make COBRA elections. If they are going to evaluate these choices at all, courts should be concerned solely that the choices were reasonable. Mr. Geissal's choice was reasonable.

Respectfully submitted,

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No. 97-689

In the Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL, BENEFICIARY AND REPRESENTATIVE OF THE ESTATE OF JAMES W. GEISSAL, DECEASED, PETITIONER

v.

MOORE MEDICAL CORPORATION, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Under 29 U.S.C. 1161(a), "continuation coverage" must be offered to employees who are participants in a group health plan and who would otherwise lose health coverage as a result of certain specified events, such as termination of employment. The employee must be provided with a specified period of time to decide whether to elect and pay for such continuation coverage. Under 29 U.S.C. 1162(2)(D)(i), such continuation coverage may end on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan" that meets certain criteria. The question presented is:

Whether an employee who has been continuously covered under a spouse's group health plan both before and after termination of employment has "first become[], after the date of the election[,] * * * covered under any other group health plan," such that the employer may terminate (or decline to offer) continuation coverage to the employee on that basis.

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INTEREST OF THE UNITED STATES

Because of its extensive administrative and enforcement responsibilities in connection with continuation group health coverage, the United States has a substantial interest in this case. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 222-237 (COBRA), as amended, added parallel continuation coverage requirements to three titles of the United States Code. Group health plans of private employers are subject to the continuation coverage requirements administered by the Department of the Treasury, 26 U.S.C. 4980B, and of Labor, 29 U.S.C. 1161-1168. The Department of the Treasury enforces

compliance through an excise tax, see 26 U.S.C. 4980B, and the Department of Labor enforces compliance through civil actions, see 29 U.S.C. 1132(a). Group health plans of state and local governments are subject to the continuation coverage requirements administered by the Department of Health and Human Services. See 42 U.S.C. 300bb-1 through 300bb-8.

STATUTORY PROVISIONS INVOLVED

The text of 29 U.S.C. 1161-1167 is reproduced in an appendix to this brief.

STATEMENT

1. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82, 222-237, as amended, requires private employers[1] and state and local governments sponsoring group health plans (other than churches and certain small employers) to afford employees and their family members the opportunity to elect to continue health coverage temporarily at group rates in certain circumstances in which coverage might otherwise terminate. This case concerns the availability of such coverage to an employee who is already covered by another plan.

The ability to elect continuation coverage is triggered by the occurrence of a "qualifying event," which is one of a number of enumerated events that would otherwise cause a "qualified beneficiary" to

[1] COBRA generally imposes requirements on plan sponsors (usually, employers) and on the plans themselves. References in this brief to the employer should be understood to refer to other plan sponsors and the plans themselves, where appropriate.

lose coverage. See 26 U.S.C. 4980B(f)(1); 29 U.S.C. 1161(a); 42 U.S.C. 300bb-1(a). The enumerated events include the employee's death, divorce or separation, termination of employment (other than for gross misconduct), or reduction of hours of employment. See 26 U.S.C. 4980B(f)(3); 29 U.S.C. 1163; 42 U.S.C. 300bb-3. A "qualified beneficiary" includes the employee (in case of his termination of employment or reduction in hours), the employee's spouse, and dependent children. See 26 U.S.C. 4980B(g)(1); 29 U.S.C. 1167(3); 42 U.S.C. 300bb-8(3). Although the plan is permitted to require the payment of a premium for COBRA continuation coverage, it generally may charge the qualified beneficiary no more than 102 percent of the "applicable premium," which is the plan's cost of coverage for similarly situated beneficiaries who have not undergone a qualifying event; that cost is determined without regard to whether it would ordinarily be paid by the employee or the employer. See 26 U.S.C. 4980B(f)(2)(C) and (4)(A); 29 U.S.C. 1162(3), 1164(1); 42 U.S.C. 300bb-2(3), 300bb-4(1). The continuation coverage is required to be identical to that enjoyed by similarly situated beneficiaries who have not undergone a qualifying event. See 26 U.S.C. 4980B(f)(2)(A); 29 U.S.C. 1162(1); 42 U.S.C. 300bb-2(1).

If a qualifying event occurs, the plan administrator is to notify the qualified beneficiary of his right to elect continuation coverage. See 26 U.S.C. 4980B(f)(6); 29 U.S.C. 1166; 42 U.S.C. 300bb-6. The election period begins not later than the date on which coverage would otherwise terminate under the plan by reason of a qualifying event; it must be of at least 60 days' duration, and it may not end earlier than 60 days from the later of the qualifying event or the date the qualified beneficiary is notified of

the right to continuation coverage. 26 U.S.C. 4980B(f)(5)(A); 29 U.S.C. 1165(1); 42 U.S.C. 300bb-5(1); see *Branch* v. *G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992). Thus, when the qualifying event is termination of employment, the election period must extend at least 60 days from the date of termination.

The issue in this case involves the provisions governing the "period of coverage." 26 U.S.C. 4980B(f)(2)(B); 29 U.S.C. 1162(2); 42 U.S.C. 300bb-2(2). After providing that "[t]he coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following," the statute sets forth the maximum required period of coverage, generally 18 months from the date of the qualifying event in the case of termination of employment. 26 U.S.C. 4980B(f)(2)(B)(i)(I); 29 U.S.C. 1162(2)(A)(i); 42 U.S.C. 300bb-2(A)(i). Several circumstances that permit cessation of continuation coverage before the expiration of the relevant maximum period are then set forth, including the employer's ceasing to provide a group health plan to any employee and the qualified beneficiary's failure to make timely payment of any required premium. 26 U.S.C. 4980B(f)(2)(B)(ii) and (iii); 29 U.S.C. 1162(2)(B) and (C); 42 U.S.C. 300bb-2(2)(B) and (C). The provision in issue here permits the employer to cease coverage on

> The date on which the qualified beneficiary first becomes, after the date of the election—
>
> > (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.

29 U.S.C. 1162(2)(D); see also 26 U.S.C. 4980B(f)(2)(B)(iv); 42 U.S.C. 300bb-2(2)(D).[2] As originally enacted, this provision did not explicitly preclude the employer from terminating coverage merely because the other group health plan excluded or limited benefits for pre-existing conditions.[3] See note 14, *infra*. In 1989,

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[2] The statute is reproduced as applicable in this case. Section 1162(2)(D)(i) and other provisions were amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, §§ 101, 102, 401, 421, 110 Stat. 1939-1943, 1955-1959, 2073-2077, 2084-2089. See App., *infra*, 1a-16a. That Act generally limited exclusion periods for preexisting conditions under group health plans to 12 months and reduced such periods by periods of "creditable coverage," including COBRA coverage and other coverage under a group health plan. See 26 U.S.C. 9801(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified); 29 U.S.C. 1181(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified); 42 U.S.C. 300gg(a)(2), (3), (c)(1)(A) and (e)(1) (to be codified). At the same time, Congress amended the pre-existing condition exclusion provisions of 26 U.S.C. 4980B(f)(2)(B)(iv)(I), 29 U.S.C. 1162(2)(D)(i) and 42 U.S.C. 300bb-2(2)(D)(i) to reflect that continuation coverage may be cut off where a plan's pre-existing condition exclusion does not apply to, or is satisfied by, the beneficiary by reason of HIPAA. HIPAA § 421, 110 Stat. 2084-2089.

[3] As originally enacted, COBRA's provisions amending the Internal Revenue Code took the form of a mechanism in 26 U.S.C. 162(i) for denying a business expense deduction for plan expenses and in 26 U.S.C. 106(b) for denying the exclusion from gross income for contributions on behalf of highly compensated individuals where plans did not meet the requirements of 26 U.S.C. 162(k). See COBRA § 10001(a) and (b), 100 Stat. 222-223. In 1988, Congress, believing that the sanctions for noncompliance should take certain ameliorative factors into account, see H.R. Rep. No. 795, 100th Cong., 2d Sess. 485-486 (1988), repealed those sanctions, and created instead the excise tax found in 26 U.S.C. 4980B. See Technical and Miscellaneous

however, Congress amended the relevant statutory sections to provide, as set forth above, that the employer may terminate coverage only if the other group health plan contains no exclusion or limitation with respect to a pre-existing condition of the beneficiary. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6701, 103 Stat. 2294.

2. Petitioner is the widow, and the personal representative of the estate, of James W. Geissal (Geissal), who died after instituting this suit. Pet. App. A1-A2, A20. Respondent Moore Medical Corp. (Moore) is Geissal's former employer and the sponsor of respondent Group Benefit Plan of Moore Medical Corp. (the Moore plan), a group health plan established for the benefit of Moore's employees. *Id.* at A2, A21-A22. Respondent Herbert Walker is the plan administrator. *Id.* at A20.

While employed by Moore, Geissal was a participant in the Moore plan. Pet. App. A2, A21. At the same time, Geissal was also covered as a dependent eligible for health benefits under a plan maintained by petitioner's employer, Trans World Airlines (TWA), through a policy issued by Aetna Life Insurance Company (Aetna). *Id.* at A2, A22. The Moore plan had an annual deductible of $150 and provided for a lifetime maximum amount of benefits, but only as to payments it made. The TWA plan had an annual deductible of $500 per person and also provided a lifetime maximum amount of benefits it would pay. *Id.* at A22.

On July 16, 1993, after working for Moore for more than seven years, Geissal was fired. He was then age 62 and ill with cancer. Pet. App. A2, A21. Geissal

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Revenue Act of 1988, Pub. L. No. 100-647, § 3011, 102 Stat. 3616-3624.

requested and received a letter from Moore under Missouri Ann. Stat. § 290.140 (West 1993), "truly stating for what cause, if any, [he] was discharged." Pet. App. A2 & n.3, A23. He considered consulting an attorney to investigate what rights and claims he might have against Moore because he felt his employment was unfairly terminated, but he decided not to do so; his main concern was that he have full and adequate health coverage. *Id.* at A3, A23. Geissal received a notice of his right under COBRA to continue group health coverage under the Moore plan. *Id.* at A22. Moore's representatives encouraged him to make the COBRA election, which did much to assuage his concerns about the effect of his discharge. At about that time, the Moore plan or its reinsurer was making large payments for medical care provided to Geissal prior to his termination. *Id.* at A23. Geissal made a timely election to continue receiving group health coverage under the Moore plan. In accordance with that election, he began making premium payments, and Moore initially accepted those payments. *Id.* at A3, A22.

Approximately six months after his termination, respondents informed Geissal that they had determined that he was not entitled to continuation coverage under the Moore plan because at the time of his termination he was already covered under the TWA plan on the basis of his wife's employment. Geissal was told that his premiums would be returned and that the Moore plan would not pay those persons who had provided him with care, but would instead return the bills to them unpaid. Pet. App. A3, A22. Although the record is not entirely clear on this point, it does not appear that respondents made any distinction in this regard between premiums paid (and bills

incurred) for the period prior to Geissal's election and premiums paid (and bills incurred) for the period following that election.

3. Geissal then brought this suit in the United States District Court for the Eastern District of Missouri, alleging that respondents had violated COBRA by failing to accord him continuation coverage. He further argued that respondents were equitably estopped from denying him such coverage, that respondents had waived any right to contest his coverage by accepting his premium payments, and that he had not received certain plan documents to which he was entitled. Pet. App. A21.

Geissal moved for partial summary judgment on the issue of whether he was entitled to elect COBRA continuation coverage. Pet. App. A23. Invoking 29 U.S.C. 1162(2)(D)(i), Geissal argued that he was entitled to COBRA continuation coverage until he "first becomes, after the date of the election[,] * * * covered under any other group health plan." He asserted that, since he had "first become[]" a beneficiary of the TWA plan *before* making his election, rather than "after" doing so, he was entitled to continuation coverage under the Moore plan notwithstanding his coverage under the TWA plan. Pet. App. A27. Respondents contended that the fact that Geissal was covered under the TWA plan when his employment was terminated served to disqualify him from COBRA continuation coverage.

A magistrate judge, sitting by consent under 28 U.S.C. 636(c), denied Geissal's motion and held, *sua sponte*, that respondents were entitled to partial summary judgment. Pet. App. A20-A36. The magistrate judge ruled that pre-existing dual coverage renders a person ineligible to elect COBRA continuation

coverage. *Id.* at A30. Geissal argued that a "significant gap" sufficient to require continuation coverage under the Moore plan existed[4] because the TWA plan had a higher deductible than the Moore plan, because coverage for some kinds of care under the Moore plan was somewhat more extensive than under the TWA plan, or because Geissal had stood to enjoy the benefit of two potential lifetime maximums (since each plan took into account only its own expenditures in computing the ceiling); the magistrate judge rejected those arguments. *Id.* at A32. The magistrate judge also granted respondents partial summary judgment, *sua sponte*, on the equitable estoppel issue. Pet. App. A35.

4. The court of appeals affirmed. Pet. App. A1-A18. In its view, "Congress was fundamentally interested in making affordable health care temporarily available to those who otherwise would find themselves 'without any health insurance coverage.'" *Id.* at A10-A11 (quoting H.R. Rep. No. 241, 99th Cong. 1st Sess. Pt. 1, at 44 (1985)). The court therefore read 29 U.S.C. 1162(2)(D)(i) as authorizing the termination of continuation coverage "on the day that a former employee becomes a beneficiary under 'any other group health plan,'" Pet. App. A11 (quoting 29 U.S.C. 1162(2)(D)(i)), and it concluded that "it is largely irrelevant under the Act whether the employee obtained that coverage before or after his COBRA

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[4] As we explain below (see pp. 25-30, *infra*), some courts that have construed the statute to allow termination of continuation coverage where the beneficiary is covered under a pre-existing plan have limited the employer's right of termination to situations in which there is no "significant gap" in coverage between the continuation plan and the pre-existing other plan.

rights are activated," *ibid.* (footnote omitted). According to the court, the language in 29 U.S.C. 1162(2)(D)(i) allowing continuation coverage to be terminated when the beneficiary "'first becomes, after the date of the election,' covered under any other group health plan * * * was not meant to absolutely insulate from the exception persons who enjoy pre-existing insurance, but was merely intended to pinpoint the day on which the presence of that coverage becomes pertinent." Pet. App. A12 (citation omitted). In the court's view, "the first time, *after the date of election*, that James Geissal became covered under his wife's plan with TWA was the very moment after the election date." *Ibid.* The court of appeals concluded that the fact that Geissal was covered under the TWA plan, as of that date, sufficed under 29 U.S.C. 1162(2)(D)(i) to allow respondents to cancel Geissal's continuation coverage, unless there was a "significant gap" between the coverage provided under the Moore plan and that provided under the TWA plan. Pet. App. A14.

The court of appeals then rejected the argument that there was a "significant gap" between the coverage of the two plans. The court stated that the gap should be measured "by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election." Pet. App. A14. The court observed that the record did not permit it to conclude that the TWA plan offered "appreciably fewer benefits" or excluded claims for any pre-existing condition of Geissal's, and that the two plans, "while not completely identical," each provided "comprehensive medical benefits." *Ibid.* It termed the two differences identified by petitioner, *i.e.*, the differences in the annual deductible and

the separate lifetime maximums, to be "rather insubstantial dissimilarities [that] fall far short of the quantum of proof necessary to demonstrate a significant gap in coverage." *Id.* at A15.[5] The court of appeals also agreed with the magistrate judge that petitioner's equitable estoppel claim failed for lack of proof of detrimental reliance. *Id.* at A17.

SUMMARY OF ARGUMENT

Under COBRA, an employer may terminate continuation coverage on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan." That language refers to a time, after the beneficiary's election to purchase COBRA continuation coverage, when the beneficiary becomes covered, for the first time, by another plan. Thus, the plain language prohibits an employer from refusing

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[5] Although the court of appeals focused on the existence of other coverage under the TWA plan immediately following the date of election as a basis for allowing respondents to cancel such coverage, it is not entirely clear from its opinion whether, in its view, respondents were permitted to cancel the continuation coverage as of the date of termination of Geissal's employment or only as of the day after the date of his election. The court of appeals did, however, affirm the magistrate judge's ruling, which apparently was based on the proposition that Geissal was ineligible for COBRA continuation coverage for any period at all. See Pet. App. A26 ("The cardinal issue between the present parties is whether James Geissal's pre-existing (Aetna) insurance coverage made him ineligible for continuation coverage with the Fund upon his termination."). We are unable to ascertain from the record here whether a holding that Geissal was entitled to such benefits for the period between the date of his firing and the date he elected continuation coverage would have entitled petitioner to any of the requested relief in this case.

to provide continuation coverage (or terminating it immediately after it is elected) on the ground that the beneficiary has been covered all along under a spouse's plan.

That conclusion is supported by the detailed, express statutory requirements that the employer must notify the beneficiary of the right to continuation coverage and give the beneficiary up to 60 days to decide whether to elect it. Congress would not have created a scheme whereby an employer must engage in a charade of that sort, knowing all along that as soon as an employee in Geissal's position elected the continuation coverage, the employer could terminate it altogether. Indeed, the sooner the employer could entice the beneficiary in that situation to elect the continuation coverage, the sooner the employer could cancel it.

An examination of Congress's purposes in enacting the COBRA continuation coverage provisions does not alter the conclusion that it is only the beneficiary's acquisition of new coverage—not maintenance of pre-existing coverage—that permits the employer to terminate continuation coverage. As attested by a number of provisions of the Act, Congress's purpose was to preserve the beneficiary's health care status quo. That purpose is served by precluding employers from terminating coverage merely because a beneficiary has all along been covered under another group health plan, regardless of the scope or adequacy of that plan. It is the beneficiary, after all, who is in the best position to decide whether his COBRA premium is warranted or would result in double coverage that is not worth the expense. Beneficiaries should not be deprived of the opportunity to maintain their prior

level of coverage and be forced to accept lesser levels of coverage they consider inadequate.

Finally, the interpretation adopted by the court of appeals and the other courts of appeals with which it agrees would immerse plan administrators in costly, difficult, and highly litigious issues. That interpretation would require an employer to provide continuation coverage if, presumably at the time of election, there is a "significant gap" between the continuation coverage offered by the employer's plan and the beneficiary's coverage under the other, pre-existing health plan. The inquiry into whether there is a "significant gap," however, would be an indeterminate one. If it required an assessment of the beneficiary's future medical needs and the extent to which those needs would in fact be covered under the new plan, then a plan administrator could not confidently make the required determination at the time of election. And even if the "significant gap" inquiry merely required an assessment of the beneficiary's current medical conditions and the coverage of those conditions under the pre-existing plan, it still would require the plan administrator to know details about the beneficiary's medical condition and the new plan that are unlikely to be readily available at the time of election. By contrast, under the construction we advocate, the plan administrator's task is much simpler: continuation coverage must be provided until the employee joins a new group health plan satisfying the statutory "no exclusion for preexisting condition" qualification after the date of election or until some other terminating event occurs. No inquiry into whether there is a "significant gap" in coverage between the old plan and the new plan need be undertaken.

ARGUMENT

THE RIGHT TO CONTINUATION COVERAGE UNDER COBRA CEASES BY REASON OF A QUALIFIED BENEFICIARY'S BECOMING COVERED BY ANOTHER GROUP HEALTH PLAN ONLY WHERE HE "FIRST BECOMES" COVERED BY THAT PLAN "AFTER THE DATE OF THE ELECTION"

This case presents the question of which of two competing interpretations of COBRA's continuation coverage provisions is correct. Two courts of appeals—the Seventh and Tenth Circuits—have held that an employer may not terminate (or refuse to offer) COBRA continuation coverage under its plan merely because a terminated employee had pre-existing coverage under another group health plan.[6] The court below and two other courts of appeals—the Eleventh and Fifth Circuits—have held that an employer may do so.[7] Although the Internal Revenue Service published a proposed regulation in 1987 that essentially endorsed the latter view, that regulation was never made final, and the IRS has now determined, upon further consideration of the matter, that the better interpretation is the one that does not allow a termination of continuation coverage on

[6] See *Lutheran Hosp., Inc.* v. *Business Men's Assurance Co.*, 51 F.3d 1308 (7th Cir. 1995); *Oakley* v. *City of Longmont*, 890 F.2d 1128 (10th Cir. 1989), cert. denied, 494 U.S. 1082 (1990).

[7] See *National Companies Health Benefit Plan* v. *St. Joseph's Hosp., Inc.*, 929 F.2d 1558 (11th Cir. 1991); *Brock* v. *Primedica, Inc.*, 904 F.2d 295 (5th Cir. 1990).

account of other, pre-existing group health coverage.[8] For the reasons given below, we submit that pre-

[8] The proposed regulations state that a qualified beneficiary's eligibility for continuation coverage ends on "the first date after the date of the election upon which the qualified beneficiary is covered * * * under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage." Prop. Treas. Reg. § 1.162-26, Q&A38-(d), 52 Fed. Reg. 22,730 (1987). On March 4, 1998, the Internal Revenue Service is releasing Announcement 98-22, noting that "after further consideration of the issue, * * * Treasury and the Internal Revenue Service now believe that the better interpretation of the statute is that a plan is not permitted to cease making COBRA coverage available merely because of other coverage (or entitlement to Medicare benefits) that began before the date of the election for COBRA coverage." *Id.* at 4 (to be published in Internal Revenue Bulletin 1998-12 (Mar. 23, 1998)). (We are lodging a copy of this announcement with the Court and serving it upon the parties to this case.) The reference to Medicare benefits is a reference to a provision that is parallel to the one at issue in this case. Under 29 U.S.C. 1162(2)(D)(ii), an employer may terminate continuation coverage on "[t]he date on which the qualified beneficiary first becomes, after the date of election[,] * * * entitled to benefits under [Medicare]."

When it published the proposed regulations, the IRS announced that, until final regulations are published, the tax sanctions for noncompliance will not apply if employers and group health plans operate in good faith compliance with a reasonable interpretation of the statutory requirements. 52 Fed. Reg. at 22,716-22,717; see also Rev. Rul. 96-8, 1996-1 C.B. 286. Compliance with the terms of the proposed regulations constitutes *per se* good faith compliance, but a failure to comply with the proposed regulations is not necessarily treated as a lack of good faith compliance, and all the relevant facts and circumstances will be taken into account. 52 Fed. Reg. at 22,717. In Announcement 98-22, the IRS is providing, for purposes of tax sanctions, for continued reliance on the proposed

existing coverage under another group health plan is not a sufficient basis for an employer to terminate or refuse to offer COBRA continuation coverage to an otherwise eligible beneficiary.

A. Under The Plain Language Of The Act, An Employer May Cease Continuation Coverage Only Upon The Beneficiary's Accession To New Coverage After The Election Of Continuation Coverage

1. The "starting point in every case involving construction of a statute is the language itself." *Greyhound Corp.* v. *Mt. Hood Stages, Inc.*, 437 U.S. 322, 330 (1978) (internal quotation marks omitted). The words of statutes "'should be interpreted where possible in their ordinary, everyday senses.'" *Malat* v. *Riddell*, 383 U.S. 569, 571 (1966) (quoting *Crane* v. *Commissioner*, 331 U.S. 1, 6 (1947)).

Under 29 U.S.C. 1162(2)(D)(i), the right to continuation coverage ends on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * covered under any other group health plan." One of the dictionary definitions of the adverb "first" is "for the first time." *Webster's Third New International Dictionary of the English Language* 856 (1986). To "become" is defined to include "to pass from a previous state or condition and come to be: grow or change into being through taking on a new character or characteristic." *Id.* at 195. It is also defined as "to come to be—used as an auxiliary in passive constructions." *Ibid.* Thus, the statutory phrase referring to the time when the beneficiary "first becomes, after the date of the election[,] * * * covered" under another plan refers to a time when the

regulation's treatment of the question presented here, pending this Court's decision in this case.

beneficiary for the first time after the date of election comes to be covered by a new plan. If the beneficiary was already covered by another plan, he cannot first become covered by it after the date of election. Unless the words "first," "becomes," and "after" are disregarded, the phrase cannot refer to a date, after the date of election, when the beneficiary merely continues to be covered by a pre-existing plan.[9] As the Seventh Circuit held in *Lutheran Hospital, Inc.* v. *Business Men's Assurance Co.*, 51 F.3d 1308, 1312 (1995), "[t]he statute clearly provides that the employee's right to continuation coverage terminates only when he or she *first* becomes, *after* the election date, *covered* by any other group health plan." See also *Oakley* v. *City of Longmont*, 890 F.2d 1128, 1132 (10th Cir. 1989) ("the plain meaning of this subsection cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage"), cert. denied, 494 U.S. 1082 (1990).

The court of appeals held (Pet. App. A12) that this provision was "merely intended to pinpoint the day on which the presence of that coverage becomes pertinent." See also *National Companies Health*

[9] The situation is parallel to that addressed by the Court in *Shalala* v. *Whitecotton*, 514 U.S. 268 (1995). In that case, the Court construed a statute in which a claimant for benefits had to prove that "the first symptom or manifestation of the onset" of an illness occurred "after vaccine administration." Id. at 274 (internal quotation marks omitted). The Court rejected the claim of a person whose first symptom or manifestation occurred before the vaccination, reasoning that "[i]f a symptom or manifestation * * * has occurred *before* a claimant's vaccination, a symptom or manifestation *after* the vaccination cannot be the first, or signal the injury's onset." *Ibid.* (emphasis added).

Benefit Plan v. *St. Joseph's Hosp., Inc.*, 929 F.2d 1558, 1570 (11th Cir. 1991). The provision would have been subject to that construction if Congress had written the statute to provide for coverage until the "date, after the date of election, on which the beneficiary is covered" by another group health plan. But Congress did not write the statute in that way, and the court of appeals' construction is accordingly mistaken.

2. Requiring an employer to provide continuation coverage until the beneficiary first becomes covered, after the date of election, by a new health plan is supported by other aspects of the statutory scheme for COBRA coverage. Under any possible reading, the statute mandates that continuation coverage be made available "beginning on the date of the qualifying event," such as termination of employment. 29 U.S.C. 1162(2). It also mandates, under any possible reading, that such coverage continue at least until the date of election, since, under 29 U.S.C. 1162(2)(D)(i), the existence of coverage under another plan is only of significance "after" that date. Thus, under any possible reading of the statute, the employer must provide continuation coverage at least until the date of election.[10]

Before the date of election, the statute imposes detailed notice requirements. The employer must generally give the plan administrator notice of the termination of the employee within 30 days of its occurrence. 29 U.S.C. 1166(a)(2). Within 14 days

[10] It is not clear that the court of appeals and some other courts with which it agrees have realized that COBRA coverage is mandatory at least until the date of election. See Pet. App. A10 (quoting statement in *National Companies*, 929 F.2d at 1558, that "[i]n effect, such an employee [with other pre-existing coverage] is ineligible for continuation coverage").

of receiving such notice, see 29 U.S.C. 1166(c), "the administrator shall notify * * * any qualified beneficiary * * * of such beneficiary's rights under this subsection," 29 U.S.C. 1166(a)(4). The beneficiary then must be given at least 60 days to decide whether to elect continuation coverage. 29 U.S.C. 1165(1)(C)(ii). If the beneficiary elects continuation coverage, the coverage generally is retroactive to the date of the qualifying event. 29 U.S.C. 1162(2).

Under the interpretation given the statute by the court of appeals, this elaborate statutory scheme would be anomalous in cases like this one, where the beneficiary had pre-existing coverage under a spouse's plan. Under that interpretation, Congress would have required employers to follow meticulous requirements in notifying terminated employees of their rights to continuation coverage and to give terminated employees a 60-day period to consider whether to accept (and pay for) such coverage; yet, as soon as an employee elected such coverage, the employer would be entitled to cut it off immediately. Moreover, the earlier the employee decided to exercise the option to elect coverage, the less coverage the employee would get. An employee who believed it to be to his benefit to elect continuation coverage immediately would sadly find that the effect of that election was to eliminate the 60 days of coverage to which he was entitled, even under the most restrictive reading of the statute. It should not readily be assumed that Congress intended to institute that kind of apparently pointless ritual.

Under our interpretation of the statute, by contrast, the entire scheme makes sense. The employee whose employment has been terminated receives notice of eligibility for continuation coverage and

has 60 days to decide whether to elect to receive it. During that period, the employee may decide whether, taking into account the existence of pre-existing coverage and other considerations, the cost of continuation coverage is warranted. If not, the employee decides not to elect continuation coverage, and the employer need not provide it. If the employee elects to purchase the continuation coverage, however, the employer must honor that election—at least until the employee becomes newly covered under some other group health plan or some other terminating event under 29 U.S.C. 1162(2) occurs. Thus, the election period serves its purpose of ensuring that affected beneficiaries have a reasonable time to sort through their economic and medical circumstances to determine whether it is worth their while to pay for continuation coverage for periods extending not only up to the date of the election, but for such time until there is a material change in their health benefit coverage or until the maximum required period expires.

B. The Purposes Of The Statute Support COBRA Coverage For Beneficiaries With Pre-Existing Coverage

1. The court of appeals indicated that its construction of the statute was dictated by what it believed to be the underlying purpose of COBRA continuation coverage. The court read a statement in the House Report on the COBRA bill to indicate that the legislation was intended to make coverage temporarily available "to those who would otherwise find themselves 'without any health insurance coverage.'" Pet. App. A10-A11 (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 44 (1985)). The

court reasoned that, if Congress was concerned only with making coverage available to those who had no health coverage, Congress would not have intended that those who had additional pre-existing coverage should be able to take advantage of the statute's benefits.

The passage on which the court of appeals relied, however, was contained in a sentence in the introductory paragraph of the pertinent section of the House Report, which described the Committee's concern with the state of health insurance coverage in the United States generally.[11] It did not purport to describe the scope of the continuation coverage provisions. Nor did the Report's subsequent description of the continuation coverage provisions itself suggest the sort of limited purpose the court of appeals posited.[12] The court of appeals therefore erred in reading a limitation into the continuation coverage provisions on the basis of a general observation in the committee report. See *Oncale* v. *Sundowner Offshore Servs., Inc.*, No. 96-568 (Mar. 4, 1998), slip op. 3 ("[I]t is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed."); *Brogan* v. *United States*,

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[11] The sentence, in its entirety, reads: "The Committee is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R. Rep. No. 241, *supra*, Pt. 1, at 44.

[12] It simply stated that a "continuation option would be available" to the specified groups, and that thereafter "[c]overage would be cancelled" if, *inter alia*, the qualified beneficiary "became covered under another group policy or medicare." H.R. Rep. No. 241, *supra*, Pt. 1, at 44-45.

118 S. Ct. 805, 809 (1998) ("[I]t is not, and cannot be, [this Court's] practice to restrict the unqualified language of a statute to the particular evil that Congress was trying to remedy—even assuming that it is possible to identify that evil from something other than the text of the statute itself.").

Indeed, in other respects, the circumstances surrounding the enactment of the continuation coverage provisions in 1986 substantially undermine the court of appeals' reliance on the passage in the House Report as support for its view that the mere fact that an employee has pre-existing coverage under his or her spouse's group plan was intended to render the employee ineligible for continuation coverage. Most significant is the text of the provisions Congress enacted.

As originally enacted in COBRA, the continuation coverage provisions permitted termination on "[t]he date on which the qualified beneficiary first becomes, after the date of the election[,] * * * a covered employee under any other group health plan," and it also permitted termination, "[i]n the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, [on] the date on which the beneficiary remarries and becomes covered under a group health plan." COBRA §§ 10001(c), 10002(a), 100 Stat. 224, 228. Under that formulation, an employer could not terminate coverage based on pre-existing coverage under a spouse's health plan, because the statute permitted termination only where, "after the date of election," the beneficiary "becomes * * * a covered employee" under any other group health plan.

The Tax Reform Act of 1986, Pub. L. No. 99-514, § 1895(d), 100 Stat. 2938, deleted the references to

reemployment and remarriage, consolidated the two provisions, and adopted the current statutory language defining the event in question as the qualified beneficiary's "first becom[ing]" covered "under any other group health plan (as an employee or otherwise)." The change no doubt broadened the varieties of new coverage that would permit an employer to terminate continuation coverage. See *National Companies*, 929 F.2d at 1570-1571. For example, an employer could not originally terminate a beneficiary who enrolled in a spouse's plan but who had not remarried, or a minor child beneficiary who obtained new coverage as a result of the remarriage of a parent; under the amended statute, the employer may terminate continuation coverage in each of those circumstances. There is no indication, however, that Congress intended in that amendment to alter the original understanding that pre-existing coverage under another plan would not provide a basis for termination. Indeed, had it wanted to do that, it could easily have altered the operative "first becomes * * * after" language that remained from the statute as originally enacted.

2. We of course agree that in enacting and amending the COBRA provisions, Congress intended at least to ensure that temporary health coverage would be available for those who would otherwise find themselves without any coverage at all. Under our interpretation, as under the interpretation adopted by the court below, the statute Congress wrote accomplishes that purpose. In our view, however, the statute serves a somewhat broader purpose as well. By distinguishing between pre-existing and after-acquired group health coverage, the statute "facilitates the preservation of the beneficiary's health care

status quo." *Lutheran Hospital*, 51 F.3d at 1312. The beneficiary is assured that, so long as he is willing to pay for continuation coverage, his health care benefits will not be altered during the temporary period (usually 18 months, if COBRA coverage is triggered by termination of employment, see 29 U.S.C. 1162(2)(A)(i)) while he seeks new employment or otherwise makes arrangements for future health care needs.

The purpose to ensure that a beneficiary willing to pay for it may maintain the health care status quo is evident in other provisions of the statute. For example, the statute does not merely require the employer to provide some minimal level of health coverage. Instead, it requires the continuation coverage to be "identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 29 U.S.C. 1162(1). That requirement supports the conclusion that Congress structured the statute not merely to provide some measure of health coverage to individuals who would otherwise have none at all, but more generally to permit covered individuals to maintain the health care status quo. Under our interpretation, that purpose is fully achieved.

That purpose appears in another feature of the statutory scheme as well. Had Congress intended only to ensure that covered employees had access to *some* health care coverage, it easily could have permitted employers to cease COBRA coverage as soon as a beneficiary "first becomes eligible" for coverage under another group health plan. Such individuals would be guaranteed access to some health care coverage, and—under the court of appeals' construction—the statutory purpose would not support any additional protection. But Congress wrote the statute to permit termination of COBRA coverage based on a beneficiary's actual coverage—not mere eligibility—under another group health plan. See 29 U.S.C. 1162(2)(D)(i) (permitting termination of coverage when a beneficiary "first becomes * * * *covered*" under another plan) (emphasis added). Congress thereby preserved a choice for the beneficiary who becomes eligible for another group health plan as a result of a new job or other change. The beneficiary may choose to join the new plan and thereby lose the right to COBRA coverage, or the beneficiary may choose to continue COBRA coverage for the maximum continuation period or until some other terminating event occurs. That option is fully consistent with our view that Congress structured the statute to give beneficiaries the right to continue the health care status quo, if they so desired, for the full COBRA coverage period.

C. The Court Of Appeals' Construction Of The Statute Would Create A Scheme That Would Be Difficult To Administer And That Would Invite Litigation

Each of the courts of appeals that has construed the statute to permit an employer to terminate coverage for beneficiaries who were covered under other pre-existing group health plans has qualified its holding to provide that an employer may not terminate coverage if there is a "significant gap" in coverage between that offered under the employer's health plan and that available under the other, pre-existing plan.[13]

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[13] See, *e.g.*, Pet. App. A12 (respondent could terminate coverage "unless there was 'a significant gap between the coverage afforded under [Moore's] plan and [Geissal's] pre-

The term "significant gap" is apparently borrowed from language in the House Report on the 1989 amendment, which addressed quite another issue—the need to enact an exception to the continuation-coverage cutoff date where the other plan under which the beneficiary becomes covered excludes or limits benefits for a pre-existing condition of the beneficiary. See Pet. App. A12 n.10 (quoting H.R. Rep. No. 247, 101st Cong., 1st Sess., at 1452-1453 (1989)). It was *that* gap in coverage to which the phrase in the 1989 House Report was specifically directed. See *id.* at 1453. Congress responded to that problem by specifying that the duty to provide continuation coverage does not terminate even when the beneficiary *does* first become covered under another plan after the date of election, if the other plan contains an exclusion or limitation for pre-existing conditions. Nothing in that decision by Congress in 1989 purports to allow an employer—by invoking a non-textual "significant gap" test—to withhold continuation coverage if the employee *does not* first become covered under a new plan after the date of election.

An amorphous "significant gap" standard, moreover, would be difficult for plan administrators to understand and apply, and would likely lead to extensive litigation. Because our interpretation of the

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existing plan' "); *National Companies*, 929 F.2d at 1571 ("If there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan, an employee will be eligible for continuation coverage."); *Brock*, 904 F.2d at 297 (noting "Congress's concern that group health plan participants and their dependents not be placed in a situation in which they suffer a gap in the character of coverage as the result of a 'qualifying event' such as termination of employment").

statute eliminates the need to conduct such an inquiry, it makes it substantially easier to achieve Congress's purpose of having a simple, easily administrable system for ensuring continuation health coverage.[14]

There is a decided lack of unanimity regarding the proper time frame for making the "significant gap"

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[14] Notably, some cases in which courts used the "significant gap" approach of comparing the respective plans' benefits in determining whether the extent of the other plan's coverage merited the loss of continuation coverage dealt with situations predating the effective date of the 1989 amendment that created an exception to the coverage cutoff where the other plan limits benefits for a pre-existing condition. Some courts in such cases found that there was a "significant gap" justifying continuation coverage where the new coverage contained an exclusion for a pre-existing condition. See *Teweleit* v. *Hartford Life and Accident Ins. Co.*, 43 F.3d 1005, 1010 & n.6 (5th Cir. 1995) (holding that the 1989 amendment did not effect a substantive change in the law, but did no more than clarify the original provision); *Conery* v. *Bath Associates*, 803 F. Supp. 1388, 1403 (N.D. Ind. 1992) (same); contra, *Martin* v. *Prudential Ins. Co.*, 776 F. Supp. 1172 (S.D. Miss. 1991). Now that the statute makes an express exception to the loss of continuation coverage where the other plan does not cover a pre-existing condition, it is clear that the most compelling reason for extending continuation coverage on a non-textual "significant gap" theory no longer exists. The fact that one plan is less generous than another simply is not a sufficient basis on which to preserve continuation coverage once the beneficiary actually becomes covered under the new plan. See *Liberty Life Assurance Co.* v. *Toys "R" Us, Inc.*, 901 F. Supp. 556, 564 (E.D.N.Y. 1995); *Daniel* v. *Master Health Plan, Inc.*, 864 F. Supp. 1399, 1406 (S.D. Ga. 1994). But whatever the merit of the decisions extending coverage under the pre-1989 version of the statute on that basis, they furnish no basis for eliminating continuation coverage that is required by the terms of the current statute.

comparison between the continuation coverage and the pre-existing coverage. Some courts have compared the results after the beneficiary has incurred medical expenses. See *National Companies*, 929 F.2d at 1571; *McGee* v. *Funderberg*, 17 F.3d 1122, 1126 (8th Cir. 1994). Other courts, including the court of appeals in this case (see Pet. App. A14), have called for comparing the coverage under the two plans at the time of the election. See *Lutheran Hosp.* v. *Business Men's Assurance Co.*, 845 F. Supp. 1275, 1289 (N.D. Ind. 1994), rev'd on other grounds, 51 F.3d 1308 (7th Cir. 1995); *Daniel* v. *Master Health Plan, Inc.*, 864 F. Supp. 1399, 1406 (S.D. Ga. 1994); *Schlett* v. *Avco Financial Servs., Inc.*, 950 F. Supp. 823, 833 (N.D. Ohio 1996).

Each approach has its deficiencies. If the existence of a "significant gap" between the continuation coverage and the pre-existing policy is viewed from an *ex post* standpoint, then it is literally impossible for a plan administrator to assess whether continuation coverage may be terminated at the time when the beneficiary makes his election—the only relevant time under the statute. On the other hand, if the existence of a "significant gap" is determined from an *ex ante* standpoint, then the inquiry requires the plan administrator to assess a host of facts—regarding the beneficiary's medical condition and the details of coverage under the new plan—that are likely to be unavailable at the time of election. In either event, the plan administrator must make widespread comparisons of each plan's coverage of numerous types of conditions and treatments, deductibles, copayments, and benefit ceilings. The need to make such a complex calculation, based on such indeterminate variables, would extraordinarily complicate

the task of the plan administrator. And, since qualified beneficiaries have a private right of action to enforce their rights to employee benefits, see 29 U.S.C. 1132(a)(1), adoption of the "significant gap" theory would be likely to spawn litigation aimed at resolution of coverage questions on a case-by-case basis.[15]

Not surprisingly, the courts have reached widely disparate results regarding what constitutes a significant gap. In *National Companies*, 929 F.2d at 1571, $6,700 in personal liability did not amount to a significant gap, nor did $7,500 in *Schlett*, 950 F. Supp. at 832-833, but in *McGee*, 17 F.3d at 1126, $6,500 did. And no significant gap in coverage was found by the district court in the case of the Guillain-Barre patient whose medical bills exceeded the Teamsters' plan's $250,000 annual cap by some $35,000. *Lutheran Hosp.*, 845 F. Supp. at 1288, discussed at note 15, *supra*. This Court should be reluctant to thrust the various federal agencies responsible for enforcing the statute, as well as employers, insurers, courts, and

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[15] For example, the quandary presented in *Lutheran Hospital* was whether there was a "significant gap" for a patient with Guillain-Barre syndrome between continuation coverage that set no yearly limit but a $1,000,000 lifetime cap on benefits and a pre-existing plan that had a $250,000 yearly maximum but no lifetime limit. 51 F.3d at 1315. The majority in *Lutheran Hospital* eliminated the need for undertaking that inquiry by adopting the view that an employer may not base a termination of coverage on the existence of pre-existing coverage under another policy, regardless of the terms of that policy. As the court observed, "[w]e agree that a *post hoc* determination of personal liability is an inappropriate way to determine preexisting legal duties. But the fictional *ex ante* approach taken by the district court is no more appropriate and completely unworkable." *Ibid.*

qualified beneficiaries alike, into a vain quest for standards for resolving particular cases under this thorny—and irrelevant—construct.

As the Seventh Circuit observed in *Lutheran Hospital*, 51 F.3d at 1315, "[t]his whole morass can be avoided by honoring the language of the statute and the decision of the insured as to how much coverage is adequate for her own situation." If the statute is construed as it is written to permit termination of coverage only if the beneficiary becomes covered under a new group health plan, the "significant gap" inquiry can be discarded. Under that interpretation, the beneficiary himself determines whether it is worthwhile to elect (and pay for) COBRA continuation coverage as well as—or instead of—the pre-existing coverage. Similarly, the beneficiary himself determines when COBRA coverage ends, by obtaining coverage under a new plan that—in accordance with the statutory standard—"does not contain any exclusion or limitation with respect to any pre-existing condition of [the] beneficiary." 29 U.S.C. 1162(2)(D)(i). That result is consonant with the basic principle underlying the COBRA provisions: that it should be left to the beneficiary—who is in the best position to gauge his own health care needs and his own willingness to pay for coverage—to compare alternative plans and decide which provides adequate coverage at rates the beneficiary can afford.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX

Title 29 of the United States Code provides in pertinent part:

§ 1161. Plans must provide continuation coverage to certain individuals

(a) In general

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

(b) Exception for certain plans

Subsection (a) of this section shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

§ 1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage

The coverage must consist of coverage which, as of the time the coverage is being provided, is

identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(ii) Special rule for multiple qualifying events

If a qualifying event (other than a qualifying event described in section 1163(6) of this title) occurs during the 18 months after the date of a qualifying event described in section 1163(2) of this title, the date which is 36 months after the date of the

qualifying event described in section 1163(2) of this title.

(iii) Special rule for certain bankruptcy proceedings

In the case of a qualifying event described in section 1163(6) of this title (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 1167(3)(C)(iii) of this title), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

(iv) General rule for other qualifying events

In the case of a qualifying event not described in section 1163(2) or 1163(6) of this title, the date which is 36 months after the date of the qualifying event.

(v) Medicare entitlement followed by qualifying event

In the case of a qualifying event described in section 1163(2) of this title that occurs less than 18 months after the date the covered employee became entitled to benefits under Title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.], the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this subparagraph before the close of the 36-month

period beginning on the date the covered employee became so entitled.

In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part, any reference in clause (i) or (ii) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 1166(3) of this title before the end of such 18 months.

(B) End of plan

The date on which the employer ceases to provide any group health plan to any employee.

(C) Failure to pay premium

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(D) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) "which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary" (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of Title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C.A. § 300gg et seq.]), or

(ii) in the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title, entitled to benefits under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.].

(E) Termination of extended coverage for disability

In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this part, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or

1381 et seq.] that the qualified beneficiary is no longer disabled.

(3) Premium requirements

The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(A) shall not exceed 102 percent of the applicable premium for such period, and

(B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to "102 percent" is deemed a reference to "150 percent" for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

(4) No requirement of insurability

The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

§ 1163. Qualifying event

For purposes of this part, the term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(3) The divorce or legal separation of the covered employee from the employee's spouse.

(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.].

(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(6) A proceeding in a case under Title 11, commencing on or after July 1, 1986, with respect to

the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 1167(3)(C) of this title within one year before or after the date of commencement of the proceeding.

§ 1164. Applicable premium

For purposes of this part—

(1) In general

The term "applicable premium" means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(2) Special rule for self-insured plans

To the extent that a plan is a self-insured plan—

(A) In general

Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such

period for similarly situated beneficiaries which—

(i) is determined on an actuarial basis, and

(ii) takes into account such factors as the Secretary may prescribe in regulations.

(B) Determination on basis of past cost

If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(C) Subparagraph (B) not to apply where significant change

An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding

determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) Determination period

The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

§ 1165. Election

For purposes of this part—

(1) Election period

The term "election period" means the period which—

(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(B) is of at least 60 days' duration, and

(C) ends not earlier than 60 days after the later of—

(i) the date described in subparagraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under section 1166(4)[1] of this title, the date of such notice.

(2) Effect of election on other beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 1167(3) of this title shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

§ 1166. Notice requirements

(a) In general

In accordance with regulations prescribed by the Secretary—

(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,[2]

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[1] So in original. Probably should be "1164(a)(4)"

[2] So in original. Probably should be "this part".

(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title within 30 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date of the qualifying event,

(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 1163 of this title within 60 days after the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C.A. § 401 et seq. or 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

(4) the administrator shall notify—

(A) in the case of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title, any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (3) or (5) of section 1163 of this title where the covered employee notifies

the administrator under paragraph (3), any qualified beneficiary with respect to such event, of such beneficiary's rights under this subsection[3]

(b) Alternative means of compliance with requirements for notification of multiemployer plans by employers

The requirements of subsection (a)(2) of this section shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (2) of section 1163 of this title if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.

(c) Rules relating to notification of qualified beneficiaries by plan administrator

For purposes of subsection (a)(4) of this section, any notification shall be made within 14 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

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[3] So in original. Probably should be "this part".

§ 1167. Definitions and special rules

For purposes of this part—

(1) Group health plan

The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of Title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of Title 26).

(2) Covered employee

The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of Title 26.

(3) Qualified beneficiary

(A) In general

The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.

(B) Special rule for terminations and reduced employment

In the case of a qualifying event described in section 1163(2) of this title, the term "qualified beneficiary" includes the covered employee.

(C) Special rule for retirees and widows

In the case of a qualifying event described in section 1163(6) of this title, the term "qualified beneficiary" includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

(i) as the spouse of the covered employee,

(ii) as the dependent child of the employee, or

(iii) as the surviving spouse of the covered employee.

(4) Employer

Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of Title 26 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of such title. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of the Treasury (or such Secretary's delegate) under such subsections.

(5) Optional extension of required periods

A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

(A) that the period of extended coverage referred to in section 1162(2) of this title commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under section 1166(a)(2) of this title commences with the date of the loss of coverage.

No. 97-689

In the
Supreme Court of the United States
OCTOBER TERM, 1997

BONNIE L. GEISSAL, as representative of the Estate of JAMES W. GEISSAL, deceased,
Petitioner,

v.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP., and HERBERT WALKER,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION

The American Association of Retired Persons (AARP) and the National Employment Lawyers Association (NELA) move for leave to file the accompanying brief *amici curiae* in support of the position of petitioner Bonnie L. Geissal, whose case is before the Court on a writ of certiorari from the judgment and opinion of the United States Court of Appeals for the Eighth Circuit.

Pursuant to Supreme Court Rule 37.3, consent of the parties to the filing of the brief was sought through counsel. Counsel for the petitioner gave consent, but counsel for the respondents withheld consent.

INTEREST OF *AMICI CURIAE*

The American Association of Retired Persons (AARP), a nonprofit membership organization of more than 32 million Americans age 50 or older, some working and some retired, is dedicated to addressing the needs and interests of older people. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In the effort to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage, from both public and private sources.

The National Employment Lawyers Association (NELA) is a voluntary membership organization of over 3,000 attorneys who regularly represent employees in labor,

employment, and civil rights disputes. It is the country's only professional membership organization exclusively comprised of lawyers who represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. As part of its advocacy efforts, NELA regularly supports precedent-setting litigation affecting the rights of individuals in the workplace.

AARP and NELA are qualified to brief the Court on this matter, as they have participated as *amici curiae* in numerous cases involving the Employee Retirement Income Security Act (ERISA), including *Boggs v. Boggs*, 117 S.Ct. 1754 (1997); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 117 S.Ct. 1513 (1997); and *Varity Corp. v. Howe*, 116 S.Ct. 1065 (1996).

AARP's members and the clients of NELA members depend in general on ERISA to protect their rights under private employer-sponsored benefit plans, 29 U.S.C. § 1001 *et seq.*, and in particular on the health care coverage protections afforded in amendments to ERISA made by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. §§ 1161-1168. The *amici* therefore have a strong and determined interest in the outcome of this case and in ensuring, to the extent possible, that the rights guaranteed by ERISA and COBRA are fully carried out.

REASONS FOR GRANTING THE MOTION

In this instance, one of the COBRA "continuation coverage" provisions, 29 U.S.C. § 1162, which is designed to offer individuals the option of maintaining their packages of group health plan coverage after leaving employment, has been ignored or misinterpreted by three appellate courts. As a result, departing employees with already existing coverage under other

group plans are denied their right to opt for continuation coverage. If this decision is upheld, workers who leave their employment will face exactly the problem which continuation coverage was designed to avoid: the prospect of sometimes devastating medical bills because of the inability to obtain, or afford, individual health insurance.

This case presents the Court with the opportunity to carry out legislative intent which Congress expressed in precise statutory language. The decision will have a direct bearing on the economic and health security of millions of Americans, including members of AARP and clients of NELA members. In light of the significance of the issue presented, AARP and NELA request that the Court grant this motion to file their brief *amici curiae*.

Respectfully submitted,

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No. 97-689

In the
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BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1/]

The interest of *amici* is set forth in the accompanying motion for leave to file this brief.

SUMMARY OF ARGUMENT

By its plain meaning, its placement, and its context, the relevant section of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986), continuation coverage provisions establishes unequivocally that continuation coverage may be terminated only when other coverage is obtained *after* continuation coverage begins. The relevant language is in a subsection titled "Period of Coverage", which states a general rule for the duration of the COBRA option. Within that subsection, four exceptions allow early termination of continuation coverage. The exception at issue permits termination only on "[t]he date on which the qualified beneficiary *first becomes, after the date of the election* [of continuation coverage] ... covered under any other group plan...." 29 U.S.C. § 1162(2)(D)(i) (emphasis supplied).

Three appellate courts have ignored this precise and unambiguous language and structure. To reach their conclusion that existing other coverage precludes the option for continuation coverage, they employ a linguistic sleight of hand, pretending that termination occurs instantaneously upon

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[1/] With the exception of the fact that counsel for petitioner, S. Sheldon Weinhaus, and counsel for the respondents, Bradley J. Washburn, are members of the National Employment Lawyers Association, and, as such, pay general membership dues, no persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

election of continuation coverage. This reading is based on one line of legislative history, which states only a Congressional concern for those with no health insurance, but ignores the broader legislative intent of offering all departing employees the opportunity to maintain the status quo of their health coverage.

Those courts' determination to rewrite the statute is underscored by their use of the "significant gap" exception. Under this entirely judge-made approach, a few individuals with existing coverage do not lose the right to select continuation coverage. The standards for the exception's application, however, are unclear and unworkable, and place the initial and primary burden on employers, not courts.

ARGUMENT

THE STATUTE'S PLAIN MEANING IS THAT THE RIGHT TO PAY FOR AND RECEIVE CONTINUATION COVERAGE IS NOT AFFECTED BY EXISTING COVERAGE UNDER ANOTHER PLAN.

By allowing an inference drawn from a few general words of legislative history to trump the precise language of the statute, *see Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1463-1464 (8th Cir. 1997), *cert. granted*, 118 S.Ct. 877 (1998), the court below ignored a fundamental precept of statutory construction: "The starting point for interpretation of a statute 'is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.'" *Kaiser Aluminum & Chemical Corp. v. Bonjorno*, 494 U.S. 827, 835 (1990), quoting *Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980). In the absence of

explicit legislative history which directly refutes the language of the statute, courts have no basis "to question the strong presumption that Congress expresses its intent through the language it chooses." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 433 n.12 (1987). Just as "the plain language" of another provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, led last Term to only one possible conclusion, *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 117 S.Ct. 1513, 1515 (1997), so too do these canons of construction require the determination that having other coverage is not an exception to a departing employee's right to select continuation coverage under the statute.

A. The Placement and Context of the Relevant Statutory Language Support its Plain Meaning.

"[M]indful that the language of a statute controls when sufficiently clear in its context," *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 201 (1976), *amici* will first provide a brief overview of the COBRA amendments in general and the specific provision at issue. Amending ERISA, the Public Health Service Act, and the Internal Revenue Code in 1986, Pub.L. No. 99-272, 100 Stat. 82 (1986), COBRA mandated continuation coverage for private and public employees.[2/]

[2/] The courts have analyzed the virtually identical COBRA provisions in ERISA and the Public Health Service Act without distinction. *See, e.g., Geissal*, 114 F.3d at 1461 n.6; *Brock v. Primedica, Inc.*, 904 F.2d 295, 296-297 (5th Cir. 1990); *Oakley v. City of Longmont*, 890 F.2d 1128, 1130 n.4 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990). Because this and most other reported decisions involve the ERISA version of the COBRA amendments, references will be to the relevant portion of ERISA, 29 U.S.C. §§ 1161-1168. The analog in the Public Health

(continued...)

Section 1161 sets out that a health plan must offer a "qualified beneficiary" the right "to elect ... continuation coverage under the plan," 29 U.S.C. § 1161(a), and the next section, 1162, provides the details of continuation coverage. *Id.*, § 1162. Section 1163 defines the "qualifying events" which trigger the right to continuation coverage; the most common of these is, as in this case, "[t]he termination ... of the covered employee's employment." 29 U.S.C. § 1163(2).

Section 1162, the section at issue, is titled "Continuation coverage", and its five subsections establish the core requirements, 29 U.S.C. §§ 1162(1)-(5), of which the first two are the most important for this discussion. Subsection 1 requires the continuation coverage to be "identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,"[1] which ensures that departing employees will receive the same coverage as those who remain employed.

Subsection 2 sets out the "[p]eriod of coverage". Its structure -- the context in which the language at issue must be evaluated -- is simple: continuation coverage must "begin[ ] on the date of the qualifying event and end[ ] not earlier than the earliest of the following" five possible events. 29 U.S.C. § 1162(2). The first of the five events is the "[m]aximum required period", which is 18 months under the "[g]eneral rule for terminations and reduced hours", *id.*, § 1162(2)(A)(i), and 36 months in the other circumstances. *Id.*, §§ 1162(2)(A)(ii)-(v). The remainder of subsection 2 lists four instances in which

[1] (...continued)
Service Act is codified at 42 U.S.C. §§ 300bb-1 to -8.

this general period of coverage could be cut short, including the one at issue, "Group health plan coverage or Medicare entitlement". *Id.*, §§ 1162(2)(B)-(E).

Congress thus established a precise, three-part timetable for continuation coverage: (1) It begins with a qualifying event (usually, termination of employment) and (2) generally lasts either 18 or 36 months, but (3) there are exceptions to that durational rule.

In relevant part, the exception at issue, subsection (2)(D), now reads:

> The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than ... [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> > (I) covered under any other group plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary ..., or (ii) in the case of a [certain type of] qualified beneficiary ..., entitled to [Medicare] benefits....

29 U.S.C. § 1162(2)(D).[2] Although there have been two

[2] Although most cases on the issue are in the context of existing coverage under a group health plan, as set out in subsection (2)(D)(i), eligibility for Medicare, which is codified at subsection (2)(D)(ii), presents an analytically undifferentiated issue. *King v. John Hancock Mutual Life Insurance Co.*, 500 N.W.2d 619, 622 (S.D. 1993) (existing Medicare coverage does not preclude right to COBRA continuation coverage).

amendments since its passage,[4] Congress has never amended the introductory language which is at the heart of this case: "[t]he date on which the qualified beneficiary first becomes, after the date of the election...." 29 U.S.C. § 1162(2)(D).

B. The Plain Meaning of the Language Does Not Permit Treatment of Existing Coverage as a Terminating Event.

The structure of section 1162(2) offers no indication that Congress contemplated that any of the early-termination dates could occur before the qualifying event that begins the "maximum required period." Furthermore, for the specific provision at issue Congress employed language which could only refer to a point in time coming *after* continuation coverage had begun: "[t]he date on which the qualified beneficiary *first becomes, after the date of the election....*" 29 U.S.C. § 1162(2)(D) (emphasis supplied). There can be no doubt as to the timing which Congress intended: termination may take place when the qualified beneficiary initially becomes eligible for other coverage after selecting continuation coverage.

The statute is explicit that a terminating event may only occur after continuation coverage has begun. First, because the "election period ... begins not later than the date on which coverage terminates under the plan by reason of a qualifying

---

[4] The first amendment changed the language in subsection (2)(D)(i) from "(i) a covered employee under any other group plan" to "(i) covered under any other group health plan (as an employee or otherwise)." Pub.L. No. 99-514, § 1895(d)(4)(B)(ii), 100 Stat. 2085, 2938 (1986); *see Oakley*, 890 F.2d at 1132. In 1989, Congress added the following language at the end of subsection (2)(D)(i): "which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary ...." Pub.L. No. 101-239, § 7862(c)(3)(B)(ii), 103 Stat. 2106, 2432 (1989).

event," 29 U.S.C. § 1165(1)(A), the phrase "after the date of the election" refers to a point in time after the qualifying event. Second, the phrase "first becomes" ("covered under any other group health plan" or "entitled to [Medicare] benefits") is an unambiguous reference to establishing eligibility for the other coverage for the *first* time. Congress was as clear as it possibly could be, and the "ordinary and obvious meaning of the phrase is not to be lightly discounted." *Cardoza-Fonseca*, 480 U.S. at 431 (citations omitted).

If the obligation to "giv[e] the 'words used' their 'ordinary meaning'" is to be taken seriously, *Moskal v. United States*, 498 U.S. 103, 108 (1990) (citation omitted), then the references to the qualified beneficiary *first* becoming covered under a new plan *after* the date of election may not be ignored. The plain meaning of the statute could not be more apparent. *Lutheran Hosp. of Indiana, Inc. v. Business Men's Assurance Co. of America*, 51 F.3d 1308, 1312 (7th Cir. 1995); *Oakley*, 890 F.2d at 1132; *King*, 500 N.W.2d at 621-622.

For judges determined to conclude otherwise, the solution to this unambiguous language has been largely to ignore it, or to dismiss it as mere "grammar and syntax". *Lutheran Hosp.*, 51 F.3d at 1315 (Coffey, J., dissenting). Thus, the Eleventh Circuit, which the court below quoted at length and "explicitly follow[ed]," *Geissal*, 114 F.3d at 1463, declined to analyze the statutory language, choosing instead to declare the intent of Congress and then to conclude, based on that intent, that "it is clearly irrelevant whether an employee had other group health coverage prior to this election date...." *National Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc.*, 929 F.2d 1558, 1570 (11th Cir. 1991); *see also Brock*, 904 F.2d at 297 (denying the right to continuation coverage because of existing coverage, without discussing the relevant statutory language).

These courts' only attempt to come to terms with the actual words of Congress underscores their inability to construct a framework compatible with that language and its context. They contend that, for employees with existing coverage, the words "first becomes" refer to a metaphysical point in time, the very instant of election: "[T]he terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date." *National Cos.*, 929 F.2d at 1570. For the petitioner, therefore, who "became covered under his wife's plan ... the very moment after the election date," *Geissal*, 114 F.3d at 1464, continuation coverage was so fleeting that it could not be measured even by an atomic clock. This is a studied attempt to devise an "acceptable" meaning from language which cannot support it.

Although this semantic game-playing is critical to the decision below, it does not comport with either the structure or the language of COBRA. It would have been a simple act of draftsmanship for Congress to include a provision denying continuation coverage to those with other coverage, *see, e.g., Inter-Modal Rail Employees Ass'n*, 117 S.Ct. at 1515 ("Had Congress intended ..., it could have easily...."), but there is no such language: "The statute does not say that an employee is ineligible for continuation coverage if he or she is covered by a preexisting group health plan." *Lutheran Hosp.*, 51 F.3d at 1312.

The framework on which the court below and others have based their conclusions in contradiction to the explicit statutory language is their view of Congressional intent. Putting aside that the language is sufficiently unambiguous -- even redundantly so -- that legislative history need not even be considered, *see, e.g., Toibb v. Radloff*, 501 U.S. 157, 162

(1991), it is evident that these courts have improperly narrowed the intent of Congress.

Although there is no legislative history on the specific provision at issue, *Lutheran Hosp.*, 51 F.3d at 1313, the courts all cite a portion of one sentence from the legislative history: "The COBRA amendments were enacted in response to 'reports of the growing number of Americans without any health insurance coverage....' H.R.Rep. No. 241, 99th Cong., 2d Sess. 44...." *National Cos.*, 929 F.2d at 1567; *see also Geissal*, 114 F.3d at 1463; *Brock*, 904 F.2d at 296. From this one statement, they infer that COBRA had only one purpose, and that purpose drives their interpretation of the provision at issue. *Geissal*, 114 F.3d at 1463-1464; *National Cos.*, 929 F.2d at 1570; *Brock*, 904 F.2d at 296-297.

This one small portion of legislative history, however, cannot effect a result at odds with the statute itself. First, a general concern for those without health insurance cannot trump explicit statutory language regarding the applicability of continuation coverage: "[V]ague notions of a statute's 'basic purpose' are ... inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Mertens v. Hewitt Associates*, 508 U.S. 248, 261 (1993) (citation omitted). Secondly, even if Congress were reacting primarily in response to those without health insurance, there is no inconsistency in also including those with other coverage: "The fact that Congress may have been motivated by the plight of a smaller sub-class -- people without any health insurance -- does not mean that in remedying the situation they necessarily limited relief to that sub-class rather than the larger group...." *Lutheran Hosp.*, 51 F.3d at 1313 n.5.

There is simply no indication that Congress was against allowing those with existing coverage to have continuation

coverage, or that to do so was inconsistent with the purpose of the COBRA amendments. Indeed, the more logical reading is that including those with other coverage within the continuation coverage option fit the general legislative pattern of providing departing employees with the choice of deciding how to proceed: "[E]ach qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect ... continuation coverage under the plan." 29 U.S.C. § 1161(a). In this respect, continuation coverage is a means of preserving "the beneficiary's health care status quo." *Lutheran Hosp.*, 51 F.3d at 1312. If the departing employee has no coverage at the time that employment is terminated, then he or she has the choice of paying the full premium in order to maintain that coverage. If he or she has other coverage, there is a comparable decision to be made: whether to rely solely on the dependent's coverage provided through the spouse's employment, or to pay the full premium for the eighteen months of continuation coverage in order to maintain whatever advantages, in the departing employee's view, the continuation coverage may provide.

That maintenance of the "health care status quo" for a limited period of time was an overall Congressional goal is demonstrated by two other aspects of the COBRA amendments. First, subsection 1162(1) requires that the continuation coverage be "identical" to the coverage provided to those "similarly situated beneficiaries" who have not left employment. Secondly, in a similar effort to guarantee that a departed employee would not suffer a reduction in coverage as a consequence of leaving employment, Congress amended subsection 1162(2)(D)(i) in 1989. This amendment precluded plans from terminating continuation coverage upon a departed employee's becoming eligible for new coverage if the new plan included a limitation for a preexisting condition. H.R.Rep. No.

247, 101st Cong., 1st Sess. 1453 (1989), *reprinted in* [1989] U.S. Code & Cong. News 1906, 2923.

C. The Failure to Accept the Plain Meaning of the Statutory Language Has Led Courts to Fabricate the "Significant Gap" Exception, Which Underscores Their Misinterpretation of the Statute.

Yet another factor underscores the mistake of the court below: the unworkable, judge-made "significant gap" exception, which has been cobbled together to ameliorate some results from denying continuation coverage to those with other coverage. Under this analysis, which has developed over the eight years since its inception,[5/] once a court has held that COBRA does not generally permit continuation coverage for those with existing coverage, it must then determine whether there was a "significant gap" between the existing coverage and the continuation coverage. *See, e.g., Geissal,* 114 F.3d at 1464. The stated rationale for this fiction is that, "[i]f there is a significant gap between the coverage afforded under his employer's plan and his preexisting plan, ... the employee is not truly 'covered' by the preexisting group health plan ...; the employee, despite his other coverage, will be liable personally for substantial medical expenses to his and his family's detriment." *National Cos.*, 51 F.3d at 1571.[6/]

[5/] Although the "gap" analysis actually had its genesis as *dictum* in the first decision concluding that the COBRA amendments did *not* deny continuation coverage to those with existing coverage, *see Oakley,* 890 F.2d at 1133, it was first applied in *Brock,* 904 F.2d at 297.

[6/] Attempting to divine some legislative authority for the "significant gap" exception, courts have suggested that it is supported by the 1989 amendment to subsection 1162(2)(D)(i), which precluded the termination

(continued...)

In addition to lacking any statutory basis, the "significant gap" exception has another drawback: its application is, and always will be, unclear and cumbersome, creating an erratic and wholly subjective standard which is nearly impossible to apply. One district judge, for instance, recently discerned three possible methodologies. *Schlett v. Avco Financial Services, Inc.*, 950 F.Supp. 823, 832-833 (N.D.Ohio 1996); *see also, e.g., Lutheran Hosp. of Indiana, Inc. v. Business Men's Assurance Co. of America*, 845 F.Supp. 1275, 1288-1289 (N.D.Ind. 1994), *rev'd*, 51 F.3d 1308 (7th Cir. 1995). Consequently, although the Eleventh Circuit held that an out-of-pocket payment of $6,700 for medical expenses because of the denial of continuation coverage did not create a "significant gap", *National Cos.*, 51 F.3d at 1571, an Eighth Circuit panel believed that a $6,500 gap was "significant" enough to trigger the exception. *McGee v. Funderburg*, 17 F.3d 1122, 1126 (8th Cir. 1994) (*dictum*). This discrepancy prompted the Seventh Circuit to ask: "Does the magnitude of personal liability sufficient to constitute a gap depend on the ability of the individual to pay or on the overall scale of their medical expenses?" *Lutheran Hosp.*, 51 F.3d at 1314 (footnote omitted).

The court below, however, rejected these *post hoc* analyses of medical expenses incurred by departed employees, directing district courts instead to

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[6] (...continued)
of continuation coverage when the newly obtained coverage had an exclusion for a preexisting condition. *See, e.g., Geissal*, 114 F.3d at 1464 n.10. But the gaps at issue in the "significant gap" analysis are the result of coverage differences between two plans, and are unrelated to the preexisting condition problem remedied by the 1989 amendment. *Lutheran Hosp.*, 51 F.3d at 1314. The courts appear to confuse preexisting plans with preexisting conditions.

> measure the gap by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election.... [T]he court should examine the policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment the beneficiary may foreseeably require."

Geissal, 114 F.3d at 1465 (citation to interior quotation omitted). That is, a district judge must compare the policies and also evaluate the former employee's past health in order to estimate what medical expenses might be anticipated in the future. It is a staggering charge, and requires the district court to make medical prognostications based on past diagnoses. In addition, the courts must fashion and apply appropriate standards of review. *Cf. Lutheran Hosp.*, 51 F.3d at 1315 ("Is the court to apply an objective or subjective standard, i.e., is it what the employer knew or what a reasonable employer should have known?").

The final unworkable component of this "morass", *id.*, is that most of the decision-making will be carried out not by judges, but by employers. Indeed, that is precisely the reason why the court below rejected the *post hoc* approach: it "gives too little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted." *Geissal*, 114 F.3d at 1464-1465 (citation omitted). Thus, the employer of a departing employee with other coverage decides, at the time of departure, whether the difference in coverage is sufficient to warrant invocation of the exception. In so doing, the *employer* not only embarks upon a quasi-legal comparison of the policies, but also evaluates the individual's medical condition in order to estimate the extent of anticipated future medical expenses. With the employer thus forced to play both lawyer and doctor, the inherent problems posed by this jerry-

rigged mechanism seem endless and irresolvable: "How does an employer calculate the gap based on whatever information he is presumed to have? Must an employer utilize an actuary and medical expert to determine the likely effect of policy differences given the patient's physical condition at the time of the qualifying event?" *Lutheran Hosp.*, 51 F.3d at 1315.

This bizarre product of a determination to ignore statutory language in favor of some courts' view of legislative intent only serves to demonstrate the flaws in reasoning which generated it. There is no need, however, to consider the complexities and problems created by the "significant gap" exception; the issue is resolved by simply applying the plain meaning of the statute, which will carry out Congress' intent to allow each employee to choose how best to maintain the status quo: "The only gap that should be relevant and judicially cognizable is that perceived by the insured individual who chooses to pay the COBRA premiums to continue her additional coverage." *Id.* at 1314.

CONCLUSION

For the reasons stated, *amici* urge the Court to reverse the decision below and to hold that 29 U.S.C. § 1162(2)(D) permits qualified beneficiaries with existing coverage to elect and maintain COBRA continuation coverage.

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March 4, 1998

(9)

No. 97-689

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL, as representative of the estate of JAMES W. GEISSAL, deceased,

Petitioner,

v.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

The Health Insurance Association of America respectfully submits this brief as *amicus curiae* in support of the respondents, Moore Medical Corp., Group Benefit Plan of Moore Medical Corp. and Herbert Walker (collectively the "Plan").1/ Both petitioner and respondents have consented to the filing of this brief. Letters reflecting those consents have been filed with the Clerk of this Court.

INTEREST OF *AMICUS CURIAE*

The Health Insurance Association of America ("HIAA"), based in Washington, D.C., is one of the largest associations of health insurance companies in the world. HIAA is an advocate for the private, market-based health insurance system. Its more than 200 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to more than 65 million Americans. HIAA develops and advocates federal and state policies which build upon our health care system's quality, affordability, accessibility and responsiveness.

To fulfill its mission, HIAA develops and advocates policy positions that will improve the health care financing

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1/ No counsel for any party in this case authored this brief, either in whole or in part. No person or entity other than HIAA has made a monetary contribution to the preparation or submission of this brief.

system. HIAA represents the interests of its members in both public and private forums. Where critical issues are involved, HIAA seeks to advance the interests of the health insurance industry (and the 65 million Americans who depend on HIAA's members for their health insurance coverage) by participating as *amicus curiae* in cases pending before federal and state courts. Because HIAA's members will be directly affected by the Court's interpretation of the "continuation coverage" provision at issue here, HIAA has a strong interest in the outcome of this case.

The sections of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"),[2] that amended the Employee Retirement Income Security Act ("ERISA"), codified at 29 U.S.C.A. §§ 1161-1169 (West Supp. 1998),[3] require both insured and self-insured employer-sponsored group health plans to offer temporary continuation coverage to qualified beneficiaries who would otherwise lose group healthcare eligibility. If the qualified beneficiary elects coverage, the employer must continue to provide coverage until a terminating event occurs.[4]

2/ Pub. L. No. 99-272, 100 Stat. 82 (1986).

3/ The COBRA amendments to ERISA will hereinafter be referred to generally as "COBRA".

4/ The provision at issue here permits termination of coverage on:

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any

(Footnote continued on next page)

For self-funded group health plans, the financial burdens of providing continuation coverage can be enormous. For insurers underwriting the risks for group health plans and the employers they insure, the requirements of COBRA are costly and create actuarial difficulties. At the same time, COBRA ensures that qualified beneficiaries and their eligible dependents have access to health care during a period of unemployment. Where a qualified beneficiary enjoys dual coverage under a spouse's employer-sponsored group health plan, the administrative and cost burdens that COBRA would otherwise impose on the qualified beneficiary's group health plan are not warranted.

For that reason, and for the reasons discussed below, COBRA should not be expanded beyond its intended scope. Accordingly, HIAA urges the Court to uphold the Eighth Circuit's finding that "[t]he Plan did not violate COBRA when it terminated [James Geissal's] continuation insurance coverage." *Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1467 (8th Cir. 1997), *reprinted in* the Appendix to the Petition for Certiorari ("Pet. App.") at A-1-A-18.

(Footnote continued from previous page)

> exclusion or limitation with respect to any preexisting condition of such beneficiary . . .

29 U.S.C.A. § 1162(2)(D)(i).

SUMMARY OF ARGUMENT

The Eighth Circuit correctly found that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i). That finding is consistent with the language of the statute, rules of statutory construction, and common sense.

Because there are two competing interpretations of the relevant provision of the statute, the court below properly turned to the legislative history. That legislative history clearly shows that Congress intended COBRA to provide "continued access to affordable private health insurance" for Americans who would otherwise be "without *any* health insurance coverage" due to loss of employment, divorce or the death of a parent or spouse. *See* Report To Accompany Recommendations From The Committee on Education and Labor, H.R. Rep. No. 99-241, 308 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 959 (emphasis added). Nothing in the legislative history indicates that Congress intended to provide for the continuation of dual coverage. Consequently, the Eighth Circuit's interpretation must be adopted because it is the interpretation that is most harmonious with the language, scheme and purpose of the statute. It also serves the public interest by protecting those who need coverage the most (i.e., those who would otherwise have no insurance) without placing undue burdens on employer-sponsored group health plans.

The Eighth Circuit's "Significant Gap" Analysis Must Be Rejected Because It Is Not Supported By The Statute. After properly finding that coverage under a preexisting group health plan constitutes "other" coverage pursuant to 29 U.S.C.A. § 1162(2)(D)(i) (Pet. App. at A-11-A-12), the court below turned to the issue of whether James Geissal's preexisting plan contained a "significant gap" in coverage. Pet. App. at A-12. The purpose of that analysis was to determine whether the preexisting plan should be exempted

from the general rule that coverage under "any other group health plan" bars continuation coverage under COBRA.

The plain language of § 1162(D)(2)(i) sets forth only one exception to the "other plan" termination provision. That exception applies to plans that limit or exclude coverage for a preexisting condition of the qualified beneficiary.[5/] The Eighth Circuit, however, did not limit its "significant gap" analysis to a determination of whether a "gap" in coverage is caused by an exclusion or limitation based on a preexisting condition of the beneficiary. *See* Pet. App. at A-13-A-15. Instead, the court embraced an expansive, judge-made rule that is nearly impossible to apply at the administrative level. Although the Eighth Circuit's analysis did not affect the outcome of this case, it creates administrative burdens and uncertainties for employers and plan administrators. If unchecked, the analysis will result in increased litigation and higher health care costs. Therefore, the "significant gap" analysis should be limited to the terms of the statute.

Public Policy Considerations Support HIAA's Interpretation Of The Statute. The claims and administrative costs of COBRA are making premiums impossible to afford. Consequently, self-insured and smaller employers who are unable to absorb the volatile risks of COBRA continuation coverage may have to cease offering group health plans altogether. Therefore, it is in the interest of the public that

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5/ As discussed *infra* at Section IIA, preexisting condition exclusions may not extend for a period of more than 12 months (18 months in the case of a late enrollee). In most cases, the exclusionary period is less. If the exclusionary period under the other plan has already expired, the termination provision would apply.

COBRA coverage be available only to qualified beneficiaries who would not otherwise be covered by a group health plan.

BACKGROUND

Each year since 1991, a comprehensive study of employers and group health plan administrators has been conducted to determine the impact of COBRA continuation coverage on employer-sponsored group health plans.[6/] The most recent survey was completed in the spring of 1997 and represents the experience of 199 employers providing ERISA health plan benefits to 1.42 million workers, 80% of whom were group health plan participants.[7/]

The 1997 COBRA Survey demonstrates the following: (1) claims costs for COBRA continuees averaged 156% of costs for active employees;[8/] (2) approximately 35% of the total costs of continuation coverage was borne by employers;[9/] (3) COBRA costs bear no practical relationship to active employee health plan costs and vary widely from benefit year to benefit year, making it impossible for employers to predict

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6/ *See* Charles D. Spencer & Associates, Inc., *1997 COBRA Survey: More Than One In Four Elect Coverage, Cost Is 156% of Active Employee Cost*, published by Spencer Research Reports on Employee Benefits, 329.04 (August 22, 1997) (hereinafter "1997 COBRA Survey").

7/ 1997 COBRA Survey, 329.04.-1.

8/ 1997 COBRA Survey, 329.04.-3.

9/ *Id.*

and budget for COBRA risks;[10/] (4) administrative costs for COBRA average $276.36 per participant annually;[11/] (5) less than one percent of COBRA continuees convert to individual health insurance policies;[12/] and (6) the average length of coverage for an 18 month qualifying event was 11.9 months, the highest in the last six years.[13/]

In addition, the 1997 COBRA Survey identified five primary difficulties in administering continuation coverage: (1) collecting premium payments; (2) managing the record-keeping burdens associated with continuation coverage; (3) becoming notified and notifying qualified beneficiaries of COBRA eligibility and changes; (4) managing the cost of coverage; and (5) complying with what the surveyed employers perceive as vague and unreasonable provisions of the law.[14/] The survey noted that these five problems have been identified as primary concerns of survey respondents during each of the last six years.[15/] Given these facts, HIAA and its members seek relief from the Eighth Circuit's unfounded (and wholly unnecessary) "significant gap" analysis.

10/ 1997 COBRA Survey, 329.04.-4 - 5.

11/ 1997 COBRA Survey, 329.04.-5.

12/ 1997 COBRA Survey, 329.04.-6.

13/ Coverage for a 36-month qualifying event averaged 21.3 months. *Id.*

14/ 1997 COBRA Survey, 329.04.-2 - 3.

15/ 1997 COBRA Survey, 329.04.-2.

ARGUMENT

I. THE EIGHTH CIRCUIT CORRECTLY HELD THAT A QUALIFIED BENEFICIARY IS NOT ENTITLED TO CONTINUATION COVERAGE UNDER COBRA IF HE OR SHE IS COVERED UNDER A PREEXISTING GROUP HEALTH PLAN.

The Eighth Circuit's finding that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i) is supported by the principles of statutory construction. Although statutory construction begins with the language of the statute itself, the underlying rule of construction is to effect the will of Congress. In enacting COBRA, Congress did not intend to guarantee dual coverage for a subset of persons. Rather, Congress intended to guarantee coverage for persons who would otherwise not be covered by any group health plan.

A. The "Plain Meaning" Rule Does Not Apply Because The Language Of The Statute Is Ambiguous.

Geissal and *amici* American Association of Retired Persons ("AARP") and National Employment Lawyers Association ("NELA") argue that the COBRA termination provision is unambiguous. They contend that § 1162(2)(D)(i) is susceptible to but one reading: only group coverage that is obtained after the date of election can terminate an employee's COBRA rights. Petitioner's Brief ("Pet. Brief") at 19; AARP/NELA Brief at 6. This interpretation of the continuation coverage provision focuses on the phrase "first becomes, after the date of election."

However, the words of a statute cannot be read in isolation, but must be considered in the context in which they are written. *Deal v. United States*, 508 U.S. 129, 132 (1993).

See also Conroy v. Aniskoff, 507 U.S. 511, 515 (1993) (Statute must be read as a whole).

By its very terms, COBRA represents a balancing of interests.16/ Its continuation provisions provide qualified beneficiaries of group health plans a transitional period during which they may continue their group health coverage while seeking to replace it. Its limitations, exclusions and termination provisions, on the other hand, confine the burdens that COBRA imposes on employers, and their group health plans.17/

Consequently, the court below correctly held that the phrase "first becomes, after the date of election" is not meant to insulate persons who are covered by preexisting insurance from the termination provision. Pet. App. at A-12. Rather, it signifies that "it is only *after* the election date that an employee's status as beneficiary under another group health plan will permit termination of COBRA benefits." *Id.* The Eighth Circuit's interpretation gives effect to the plain meaning of COBRA in a manner that reconciles all of its provisions.18/

16/ *Compare*, 29 U.S.C.A. § 1161 (mandating that continuation coverage be provided to certain individuals) *with* § 1162(2) (defining the circumstances under which continuation coverage may be terminated).

17/ *See, e.g.*, 29 U.S.C.A. § 1162(2)(A) (providing a maximum period for which benefits must be continued).

18/ Because COBRA provides a 60-day election period (29 U.S.C.A. § 1165), the phrase "after the date of election" protects qualified beneficiaries who lose dual coverage before their election date. It also permits beneficiaries who are covered by a preexisting plan to terminate the preexisting plan

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In particular, the Eighth Circuit found the following rationale of the Eleventh Circuit in *Nat'l Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc.*, 929 F.2d 1558, 1570 (11th Cir. 1991), persuasive:

> [I]t is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date. In effect, such an employee is ineligible for continuation coverage.

Pet. App. at A-9-A-10. Consequently, Geissal's interpretation of the statute is not the only construction that gives meaning to its terms.

Geissal's argument that the statute is unambiguous is further belied by the fact that well-informed persons have read the text differently. Several courts (including three courts of appeals) and the Treasury Department[19/] have interpreted COBRA's continuation coverage provision to permit the termination of continuation coverage where the beneficiary had

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before the election date if they determine that the COBRA plan is more beneficial.

19/ The Treasury Department is authorized by Congress to promulgate COBRA insurance regulations. *Cf.* 29 U.S.C.A. § 1168.

preexisting coverage under another group health plan.[20/] Because there is no consensus on the plain meaning of the statute, Geissal's argument that it is unambiguous, must fail.[21/]

B. The Eighth Circuit's Interpretation Of The Continuation Coverage Provision Must Prevail Because It Is The Construction That Most Fully Promotes The Purpose Of The Statute.

When there is more than one possible reading of a statute, the Court's duty is "to find that interpretation which can most fairly be said to be imbedded in the statute, in the sense of being most harmonious with its scheme and with the general purposes that Congress manifested." *Comm'r of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984) (*quoting NLRB v. Lion Oil Co.*, 352 U.S. 282, 297 (1957)).

Geissal argues that "[t]he legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized. . . . As a result, most of what one finds when attempting to discern the legislative intent behind various statutory passages from extrinsic materials are pontifications by Congressional Committees in after-the-fact reports." Pet. Brief at 40-41. Although the legislative history is scant, it shows

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20/ *See* Brief of *amicus* United States ("U.S.") at 14 (stating that the Internal Revenue Service's ("IRS") 1987 proposed regulation endorsed the view adopted by the Fifth, Eighth and Eleventh Circuits). *See also*, 52 Fed. Reg. 22716, 22730 (Proposed Rules of the IRS, Dep't. of Treasury).

21/ The recent decision of the IRS to endorse Geissal's interpretation as the "better interpretation" (Brief of U.S. at 14-15), effectively illustrates that the provision is subject to two constructions.

COBRA continuation provisions were intended to provide "continued access to affordable private health insurance" for Americans who would otherwise be "without *any* health insurance coverage" due to loss of employment, divorce or death of a parent or spouse. Report To Accompany Recommendations From The Committee on Education and Labor, H.R. Rep. No. 99-241, 308 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 959 (emphasis added). *See also* Finance Committee Reconciliation Report, S. Rep. No. 99-146, at 363 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 322 ("The committee was concerned that certain spouses and dependent children may be *deprived* of health benefits due to an unexpected change in family status.") (emphasis added); H.R. Rep. No. 99-241, at 44 (1986), 1986 U.S.C.C.A.N. 42, 622.

Thus, the Eighth Circuit's holding that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i) is consistent with the purpose of the statute. By contrast, Geissal's interpretation lacks support in the legislative history. It is based on an assumption that Congress intended to preserve the status quo for all individuals, including those who were covered under another group health plan.[22/] Neither the

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22/ *Amici* AARP and NELA rely on 29 U.S.C.A. § 1162(1) to support the position that Congress intended to preserve the beneficiary's status quo. AARP/NELA Brief at 10. Geissal does so indirectly by relying on *Lutheran Hosp. of Ind. v. Bus. Men's Assurance Co. of America*, 51 F.3d 1308 (7th Cir. 1995), which, in turn, depends on § 1162(1). *See* Pet. Brief at 34 (*citing Lutheran Hosp.*, 51 F.3d at 1313). Section 1162(1) requires that continuation coverage be "identical to the coverage provided . . . to similarly situated beneficiaries [for] whom a qualifying event has not occurred." It also provides

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legislative history nor the policies behind the statute, however, support such a finding.[23/] Therefore, the Eighth Circuit's interpretation, not Geissal's, must prevail.

II. THE EIGHTH CIRCUIT'S "SIGNIFICANT GAP" ANALYSIS MUST BE REJECTED.

A. A "Significant Gap" is Only Created Where There are Limitations or Exclusions on Coverage for Preexisting Conditions.

As stated above, the goal of Congress in enacting COBRA was to protect uninsured Americans. Prior to 1989, the statute permitted continuation coverage to be terminated on:

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that, if coverage is modified for other plan beneficiaries, it "shall also be modified in the same manner" for the qualified beneficiaries. § 1162(1). That section does not protect the status quo for individuals with preexisting coverage. Rather, it insures that qualified beneficiaries electing COBRA receive the same quality of benefits as other beneficiaries in the same plan.

23/ In opposition to a 1995 proposal to eliminate the mandatory minimum period during which employers must offer continuation coverage under COBRA, Rep. Archer stated that "The intent of the COBRA continuity provisions . . . is to offer a transitional benefit for employees and their dependents when they lose health coverage as a result of a qualifying event. . . . Extending COBRA continuity beyond its intended purpose would not only increase health care costs for employers and employees, but may even make coverage unaffordable for some employers now offering coverage." 141 Cong. Rec. H1912-06, H1951-52 (daily ed. Feb. 21, 1995). Similarly, expanding the requirement of continuation to preserve dual coverage may have the same negative effects.

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise).

29 U.S.C.A. § 1162(2)(D)(i) (1986). Congress recognized that, where a qualified beneficiary is covered by another plan and that plan excludes coverage for preexisting conditions, that individual is uninsured for a preexisting condition during the period of exclusion. *Cf.* H.R. Rep. No. 101-247, reprinted in 1989 U.S.C.C.A.N. 1906, 1943. Therefore, Congress amended § 1162(D)(2)(i) to preclude termination of continuation coverage based on the beneficiary's coverage under another health plan if the other plan contains an "exclusion or limitation with respect to any preexisting condition of such beneficiary."

The statute now states that continuation coverage may be terminated on:

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary
> . . .

29 U.S.C.A. § 1162(2)(D)(i) (West Supp. 1998).

The preexisting condition limitation is the only exception to the "any other group health plan" termination provision set forth in § 1162(D)(2)(i). Hence, the only exclusion recognized in the statute is for plans that contain exclusions or limitations based on a preexisting condition of the beneficiary. Accordingly, the only determination that needs

to be made is an objective one: whether the preexisting (or newly acquired) group health plan contains limitations or exclusions relating to a preexisting condition of the beneficiary and, if so, whether the exclusionary period is still in effect.[24/] If the policy does not limit the beneficiary's coverage for a preexisting condition, COBRA continuation rights under the employer's plan may properly be terminated.

The Eighth Circuit nevertheless adopted a test that would require plan administrators and courts to examine the two policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment that the beneficiary may forseeably require." Pet. App. A-14 (*quoting Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)). In the instant case, the Eighth Circuit considered, *inter alia*, the difference in yearly deductibles and lifetime maximums on benefits. It concluded that these differences did not amount to a

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24/ In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936 (1996)), codified at 29 U.S.C.A. § 1181-1191c. (West Supp. 1998) as an amendment to ERISA. Section 1181(a)(2) limits the period for which a group health plan may impose a preexisting condition exclusion or limitation. Such exclusions may not extend "for a period of more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date."

For purposes of § 1181, a "preexisting condition exclusion" is defined as "a limitation or exclusion of benefits relating to a condition *based on the fact that the condition was present before the date of enrollment.*" § 1181(b)(1)(A) (emphasis added).

"significant gap in coverage." *Id.* This depth of analysis, however, is not required by the statute.25/

In enacting COBRA, Congress provided a general mechanism by which qualified beneficiaries could obtain transitional insurance coverage at group plan rates. Were Congress concerned with the specific costs to the beneficiary, such as copayments, deductibles and premiums, it could have regulated these charges, or it could have defined the terms of replacement coverage.

The confusion regarding what constitutes a "gap" is created by the inappropriate focus on the differences in specific terms and obligations of the policies under comparison. The fact that Congress did not intend the focus to be on such

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25/ The term "significant gap" does not appear in the statute. It was borrowed from the legislative history, which states that the 1989 amendment was:

> "intended to carry out the original intent of the health care continuation rules, which was to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage. If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion."

H.R. Rep. No. 101-247, reprinted in 1989 U.S.C.C.A.N. 1906, 1943. As the amendment itself shows, Congress was concerned with a "gap" resulting from a preexisting condition, not the indefinite number of gaps contemplated by the Eighth Circuit's analysis.

differences is demonstrated by the word "any" in the phrase "any other group health plan." *See* § 1162(2)(D)(i). The impropriety of focusing on discrete differences between plans is further supported by Congress' enactment of § 1162(2)(D)(ii). That section permits the termination of COBRA coverage when a qualified beneficiary becomes entitled to Medicare benefits. Compared to most group health plans, Medicare offers limited benefits.26/ For example, Medicare does not provide coverage for prescription drugs. Yet, that is a common benefit provided by most group health plans.

The appropriate focus, which Congress intended, is upon the potential for loss of coverage due to the beneficiary's preexisting condition. Thus, under the terms of the statute, the so-called "gap" is simple to discern: it is an exclusion or limitation contained in the replacement policy regarding preexisting conditions. Any other purported "gap," such as a discrete difference in benefits or a difference in copayment or deductible requirements, is not a cognizable difference under COBRA. Such "gaps" should not have been considered by the Court below.

B. The "Significant Gap" Analysis Adopted By The Eighth Circuit Is Unworkable, Puts Plan Administrators At Risk And Results In Increased Costs To Plans And Plan Beneficiaries.

HIAA and the *amici* who support petitioner herein agree that the Eighth Circuit's "significant gap" test is not only

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26/ *See* 42 U.S.C.A. § 1395d (1992 & West Supp. 1997) (setting forth the Medicare Part A insurance benefits); 42 U.S.C.A. § 1395k (1992 & West Supp. 1997) (setting forth the Medicare Part B supplemental insurance benefits).

contrary to the terms of the statute, but is also unworkable. *See* Brief of U.S. at 13; Brief of AARP/NELA at 12. It requires the plan administrators to analyze the two plans on a benefit-by-benefit basis and to make judgments about an individual's perceived health needs.[27/] It is difficult, if not impossible, to apply and invites costly litigation.

As the court below noted, the detractors of the "significant gap" test have criticized it on the basis that its application will lead to "an inappropriate *post hoc* determination" that gives "little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted." Pet. App. at A-13. In confronting this criticism, the Eighth Circuit developed "a framework which [it believed] is less dependent upon hindsight." *Id.* at A-14. To that end, the Eighth Circuit held that the gap should be measured "by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election." *Id.*

While the Eighth Circuit's analysis provides some guidance, it still lacks the clarity and simplicity that will permit an analysis to be undertaken at the administrative level. Consequently, in many cases, resort to the courts will still be required. In fact, the Eighth Circuit invites this result: "We believe a district court confronted with this question should measure the gap by comparing the policies' provisions in light of information available to the employer on the day of COBRA election." Pet. App. at A-14. *See also id.* ("[T]he court should

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27/ Those decisions are more appropriately made by the qualified beneficiary, who, given a 60-day election period, can decide whether he or she is better off with the COBRA coverage or coverage under another health plan. *See supra* note 18.

examine the policies. . ."). To suggest that the "gap" determination be made by the courts is impractical. It is also unfair to employers and plan administrators due to the significant sanctions which may be assessed against them for violations of ERISA,[28/] including violations of its COBRA requirements.

The Eighth Circuit's "significant gap" test places excessive burdens on employer-sponsored group health plans. It results in an inefficient delivery of health insurance benefits and increased health care delivery costs, thereby negatively impacting the employer-sponsored group health plan benefits system upon which so many millions of Americans depend for their health insurance needs.

In contrast, the construction urged by HIAA is relatively simple to apply. The plan administrators who are required to make the determination of entitlement to continuation coverage need only look for an exclusion based on a preexisting condition and to determine whether that exclusion is currently in effect. Thus, a determination of the applicability of COBRA to a particular situation can be appropriately made by the group health plan administrator, rather than by the courts. This is the only approach that serves both the language of the statute and the Congressional purpose of protecting certain qualified beneficiaries from periods of complete loss of health insurance coverage, while at the same time not over-burdening employer-sponsored group health plans.

28/ *See, e.g.*, 26 U.S.C.A. § 4980B (1989 & West Supp. 1997) (imposing excise taxes); 29 U.S.C.A. § 1132 (1985 & West Supp. 1998) (permitting, *e.g.*, civil enforcement actions by beneficiaries, injunctive actions by the Secretary of Labor, and penalties of up to $100 per day for violations of notice requirements).

III. BECAUSE COBRA PLACES EXCESSIVE BURDENS ON EMPLOYER-SPONSORED GROUP HEALTH PLANS, THE COURT SHOULD AVOID IMPOSING REQUIREMENTS ON GROUP HEALTH PLANS THAT ARE NOT MANDATED BY STATUTE

COBRA coverage for dually-covered individuals is particularly difficult and expensive to administer. It requires the employer or plan administrator to compare both plans to determine whether its coverage is primary or secondary, and to determine whether any special coordination of benefits rules apply.29/ Dual coverage also imposes double administrative burdens on the health care benefits delivery system, increasing costs for all participants. The adoption of the Eighth Circuit's "significant gap" test will only lead to further administrative burdens. Because dually-covered workers are already guaranteed some form of health insurance coverage by another group plan, they need COBRA continuation coverage the least of any group of potentially qualified beneficiaries.

Further, the burdens of dual continuation are disproportionately shifted to (1) employers and plans that absorb a portion of the administrative and claims costs, (2) active employees who may lose all or some of their coverage because their employer can no longer afford to sponsor it, and (3) other qualified beneficiaries who must decline continuation coverage because it has become too expensive. Consequently, the Court should not expand the protections for beneficiaries who are covered by another group health plan to the detriment

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29/ For an indication of the inquiry entailed in a coordination of benefits analysis, see National Association of Insurance Commissioners Group Coordination of Benefits Model Regulation, NAIC 120-1 (April 1997).

of the other plan participants, particularly where Congress has not required such a result.

In sum, COBRA is costly to employers, and its costs may adversely impact the group health plan benefits available to active employees. While these costs may be justified to afford health insurance coverage to those who may otherwise lose it, they are unwarranted in situations where an individual has dual coverage incidental to having a working spouse.

CONCLUSION

For the foregoing reasons, HIAA urges the Court to affirm the decision below and to hold that a qualified beneficiary is not entitled to continuation coverage under COBRA if he or she is covered by a preexisting group health plan unless the preexisting plan contains an exclusion or limitation regarding a preexisting condition of the beneficiary.

Respectfully submitted,

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